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CONCERNING THE NATURE OF COMMUNICATION*

BY ERIC BERNE, M. D.

I. Cybernetics and Psychiatry

The physical and engineering aspects of control devices, calculators and communication systems[1] are now related to a body of precise theory.[2] This science, which has been called cybernetics[3] is gradually expanding into territory which is familiar from another point of view to psychologists, psychiatrists, and psychoanalysts. Cybernetics leads from consideration of physical devices like telegraph cables to attempts at precise mathematical analysis of such formulations as for example, the following: "numerous observations—comparison—thinking—scientific laws—practical application of these laws—new apparatus or machines built."[4]

The inspection of such a sequence makes it clear that students of mental science have a pertinent interest in these developments. Communication theory has a great deal to say about the mechanics of certain operations at which living organisms are peculiarly adept, especially in connection with the ability to respond selectively to signals received.[5, 6] Cybernetics has hitherto received relatively little attention in the psychiatric literature, although a good deal of discussion by clinicians is mentioned or found in sources not ordinarily consulted by clinicians.[3a, 7] Some physiologists have actually constructed cybernetic mechanisms as representatives of brain function.[8, 9, 10] Shannon[5] proposes a chess-playing machine. Meanwhile, the psychological aspects of communication have aroused considerable interest.[11]** But the number of fortunate people who have had both intensive training in the theory and practice of communication engineering and extensive experience in dynamic psychotherapy appears to be stringently limited. The specialist in either field hesitates to venture as a layman into the other because of the pitfalls which tempt the uninitiated in such complex matters. Nevertheless it seems worth while to run some risks for the sake of scientific empiricism.

*Modified from a paper read at the Psychology Seminar of the Langley Porter Clinic, San Francisco, March 1950.

**Dr. W. R. Ashby of Gloucester, England, conducted the meeting on cybernetics at the International Congress of Psychiatry in Paris in 1950. At this meeting, which was attended by a group with quite heterogeneous viewpoints, little inclination was shown to discuss the subject from the psychological point of view.

Some "cyberneticists" mention or even emphasize the analogies between their machines and the brain, or even the mind: "The realization that the brain and the computing machine have much in common may suggest new and valid approaches to psychopathology, and even to psychiatrics."[3b] Others stress the essential differences: "Active thinking has been done by the designers of the machine and is done by the staff of scientists using the machine. Creative thinking is not to be found in the machinery itself."[4]

Cyberneticists, coming in one direction from theoretical physics and practical experience with communication systems and calculating machines, are able to state: "The information carried by a precise message in the absence of a noise is infinite. In the presence of a noise, however, this amount of information is finite, and it approaches 0 [zero] very rapidly as the noise increases in intensity."[3c] "No communication mechanism, whether electrical or not, can call on the future to influence the past, and any contrivance which requires that, at some stage, we should controvert this rule, is simply unconstructible . . . once a message has been formed, a subsequent operation on it may deprive it of some of its information, but can never augment it."[12]

What has the psychotherapist, coming in the other direction from his clinical work, to say about these statements? He can make certain comments and discuss them on the basis of his own experience: First, that the notion of "a precise message" or "a message which has been formed" is psychologically inconceivable in interpersonal communication. Second, that in contrast to mathematical "information," the amount of psychological information increases rather than decreases with increasingly intense (intrinsic) "noise." Third, that human beings, in their interpersonal communications, do seem to call successfully on the future to influence the past.

The mathematician is able to discuss "noise" and "information" from a formal, syntactic point of view in terms of entropy,[2, 3, 4] relating them as quantities to formulations of the second law of thermodynamics. The psychologist regards noise and information semeiotically from the pragmatic aspect. According to the common notion, as expressed in dictionaries, *noise* means "a disturbing or discordant sound." It is an emotional word. To say, "I hear a noise!" still means to most people, "I am disturbed." To say, "I have information!" means, "I know something." The common no-

tion of noise usually connotes "what I don't want to hear," and of information "what I do want to hear." The mathematician, in speaking, for example, of "combating noise" and "undesirable uncertainty," seems to accept these axiological connotations,[2a] which the psychiatrist expresses as the anxiety aroused by noise and the feeling of security which comes from knowing something, respectively.

Since the psychiatrist is generally not equipped to deal rigorously with the mathematical concepts of "noise" and "information," it is fortunate that the mathematician sometimes indicates, implicity and explicitly, that his discussions of these two quantities are influenced by the concepts of "desirability" and "intention." This provides a common area where the two disciplines overlap in their study of communication. If the psychiatrist defines information from the communicant's point of view as what he advertently desires and intends to communicate, and noise as what he inadvertently communicates without desiring or intending, an interesting situation arises. If we term the communicant for the moment a "machine," this may be stated as follows: Noise is the only factor which communicates operationally anything about the variable state of the machine itself. Information can communicate nothing about this except as a proposition whose verification depends upon scanning the noise. A machine which worked without noise would communicate nothing about the variations in its own state. When a message is desired about those variations, it must be derived from noise.

In interpersonal communication, such a message may be desired by the receiver. From the receiver's point of view, information can be defined as what he advertently desires and intends to receive, and noise as what he inadvertently receives without desiring or intending to receive. The reception of noise by the receiver interferes with his reception of information so that his reception is equivocal. If the receiver (in interpersonal communication) is interested in an apparently precise, formed message which the communicant desires and intends to transmit, then their definitions of noise and information coincide. But if the receiver is interested in the state of the communicant, then what is noise to the communicant becomes information to the receiver, and what is information to the communicant becomes noise to the receiver, since it interferes with his clear reception of the message he desires to receive

so that his reception is equivocal. Thus in the psychological situation, what is information at one moment can become noise at the next moment, and vice versa, by a mere change of attitude on the part of the receiver. Furthermore, since the receiver can re-evaluate what has already happened, what was noise in the past can become information in the future, and vice versa. The situation is somewhat analogous in the case of machines, insofar as they are objects of human observation. Although these statements are based on a shift in defining "noise" and "information" from the syntactic to the pragmatic point of view, they nevertheless present aspects to be considered in any mathematical theory of communication which takes psychological factors into account.

This position can be generalized psychologically in the following proposition: In the case of any machine which is a "black box" (the communicant), the amount of information which can be derived concerning the state of the machine itself is a direct function of the (intrinsic) noise. If the machine functions perfectly, this type of information is limited to the information that it is functioning perfectly. Specifically, a theoretically perfect diplomat reveals nothing of his inner life. The only information he communicates about himself to others is that he has perfect manners. On the other hand, the ambivalence of an ardent lover or a deadly enemy is communicated only by the noise, if any, which contaminates the precisely formed message he intends to convey. It might be possible to increase the area of mutual understanding between cybernetics and psychology by analyzing this proposition in terms of entropy in such a fashion as to make the analysis psychologically cogent. P. W. Bridgman[13] pointed out the difficulty in dealing in terms of entropy with any system containing living organisms. This difficulty may arise *a fortiori* in the case of psychological systems; nevertheless, some psychologists have been sufficiently intrigued by the possibility to write about it.[14]

It might appear that the problem is no more complex than dealing by communication theory with a talking movie of a person who is not acting, so that, for example, the sound track and the pictures may be regarded as noise and information respectively, or vice versa. But it is not that simple. In interpersonal communication, the message is not manifest immediately to the receiver any more than it is to the communicant; and both parties may be exerting strenuous efforts to confuse noise with information, and vice

versa. Common clinical examples of these deceptive maneuvers are as follows: 1. "I'm talking a lot, therefore I'm telling you a lot." 2. "My slip of the tongue was accidental, therefore you must not judge me by it." 3. "He says he loves me, therefore he does." 4. "She forgot my birthday because she is absent-minded." Whether it is possible to relate these complications to matters which the mathematician is already capable of dealing with, such as memory and coding, remains to be seen.

II. The Latent Communication

The position taken here that is to be justified heuristically in regard to interpersonal communication, especially in the clinical situation, is as follows: That the notion of "a precise message" is psychologically inconceivable; that the amount of potential psychological information increases rather than decreases with increasingly intense (intrinsic) noise; that the future can be successfully called upon to influence the past.

The crux of the matter from the psychological viewpoint is the differentiation between "manifest communications" and "latent communications." To illustrate this, it is convenient to consider first a communication which is indirect in time, place, and person, such as a message from antiquity.

An interesting and cogent example is the Rhind Papyrus.[15] Thirty-six hundred years ago, an Egyptian scribe named Ahmose was attempting to communicate to some countrymen a clever method of dealing with problems in arithmetic. Reading the English translation today, one cannot help being interested in the manifest communication, which describes a fascinating but highly inefficient method of solving such problems. This method is what Ahmose desired and intended to communicate. But to the modern reader, even more interesting is what he did not advertently intend to communicate, the communication latent in his papyrus, which concerns, among other things, a certain amount of carelessness, a lack of intellectual integrity, a preponderant interest in food and how to preserve it from the ravages of mice, and an undemocratic attitude.

A prehistoric kitchen-midden is an even more striking example of a latent communication, since it was not intended as a communication at all and yet communicates a great deal to future generations, e. g., dates.[16]

With this preparation, one can approach the more subtle situation met with in the direct, *vis-à-vis* communications of clinical practice. At a certain stage of his treatment, a patient bought a recording machine. He would dictate his dreams during the night and proudly bring the machine to the psychiatrist's office in the morning and run them off. This was intended to demonstrate his efficiency and co-operation, but instead showed his fear of interpersonal relationships and his hostility to the psychiatrist. He filled the machine with manifest communications which were of far less importance at the time than the latent communication signified by his purchase of the machine for this sole purpose. Furthermore, his eulogies of the machine inadvertently revealed far more about himself than they did about the recorder.

From the consideration of examples such as these, it becomes evident that the value of a communication (to the receiver) cannot be set by the communicant, but only by the receiver. No matter how anxious the communicant is to form a precise message, his communication cannot be limited to what he intends. Furthermore, the unintended communications, which from his point of view are "noise," are of more psychological value than the intended ones. But this depends on what the receiver regards as information; the patient's wife, for example, was unable at the time to see any significance in his purchase of the machine. During her own subsequent treatment, however, it happened that a great many of her husband's actions which she had previously ignored now became very informative, so that what had previously seemed like a lot of noise was transformed into information, particularly when she took the timing and the status of the communicant into account. Similarly in the case of the papyrus, the precise message which Ahmose intended is not so precise after all, and the less precise it is, the more we learn about Ahmose and his people, mainly because our distance in time from their culture enables us to be more objective. The random, disarranged, and once noisome kitchen-midden also becomes very informative after the lapse of many centuries.

In the case of interpersonal relationships, in general, intended, precise, formal, rational, verbal communications are of less value than inadvertent, ambiguous, informal, nonrational, nonverbal communications; for in such cases the receiver is not interested in the information the communicant intends but in the psychological

reality behind it.* "Arithmetical problems about granaries can be solved," means at the most superficial psychological level: "I am interested in granaries"; and "I am co-operative" means "*I feel I* should tell *you* at this *time* that I am co-operative."

These observations make certain defining statements possible from the psychological point of view. Any emission of energy which affects an organism may be called a communication, providing it is understood by the receiver. For example, Mario Pei refers to "the broader definition of language" as "any transfer of meaning."[18b] Whatever can be understood is a *communication.* Whatever cannot be understood is not a communication. Only a person who understands the actions of bees can receive communications from them.[21] An image on a television screen is a communication to the public; "snow" on the screen is a communication only insofar as the receiving organism understands how television works.

A communication is *understood* when it changes the distribution of psychic cathexes in the receiving organism. Any change in the psychic cathexes in an organism, such as that brought about by a communication, changes its potentialities for action. Cathexis refers to the charge of "psychic energy" on a psychic image, and the investment of such an image with feeling and significance. Not everything which changes cathectic distribution and, hence, poten-

*These are principles well known explicitly or implicitly to all psychiatrists and psychologists, and for that matter to all physicians. The probability of their validity is increased by the fact that students of other disciplines, viewing other aspects, come to similar conclusions. Among linguists, for example, E. H. Sturtevant (Ref. 17) takes an almost cynical position: "All real intentions and emotions got themselves expressed involuntarily, and as yet nothing but intention and emotion had called for expression. So voluntary communication can scarcely have been called upon except to deceive; language must have been invented for the purpose of lying." Concerning the specificity of nonverbal communications, another linguist, Mario Pei (Ref. 18), says: "It is further estimated that some seven hundred thousand distinct elementary gestures can be produced by facial expressions, postures, movements of the arms, wrists, fingers, etc., and their combinations." Seven hundred thousand is more than the number of words in the English language, including a few hundred thousand archaic and technical terms (Ref. 18a).

Still, as to the relative values of verbal and nonverbal communications, there are contrasting viewpoints. Darwin (Ref. 19) says: "The movements of expression . . . serve as the first means of communication. . . . They reveal the thoughts and intentions of others more truly than do words, which may be falsified." Freud (Ref. 20) remarks on the other hand: "Speech owes its importance to its aptitude for mutual understanding in the herd, and upon it the identification of the individuals with one another largely rests."

tialities for action, is a communication: Metabolic changes, fantasies, and dreams may do the same thing. The *value* of a communication is the extent to which it changes quantitatively the cathectic distributions in the communicant and the receiver and, hence, their potentialities for action. The value is the quantitative aspect of the quality of being understood, and changes on a time scale. It is principally discussed here from the receiver's viewpoint. *Interpersonal* communication generally refers here to *vis-à-vis* communication which influences the development of the relationship between the autonomous portions of the personalities concerned. *Intend* (in this discussion of the latent communication) is used with its common dictionary implication of conscious design, determination, and direction.

III. Clinical Applications

In the case of machines, there are at least two kinds of messages received: One is the message which is put into the machine as information; another is the message which the machine sends about its own state as noise. Similarly, there are two kinds of communications between people: One refers to the manifest topic of communication, the other to the state of the communicant. The latter, as psychiatrists know, is generally latent, for if a man is asked: "How are you?" he reveals the true state of affairs, not by the manifest content of his reply, but by his manner, his choice of words, and a multitude of other clues. It has been traditionally agreed for at least five thousand years that in the development of interpersonal relationships, the state of a communicant (with regard to *Maat* or righteousness, for example) is more important than what he or she is saying. In the present terminology, the latent communication is generally of more value in this regard than the manifest communication. Its superior value is well known to the layman who remarks: "It's not what she says, it's the way she says it!"

There must be some way for the receiver to understand the latent communication. With a certain part of his ego, the communicant tries "to form a precise message." But what comes out is a configuration to which many functions make their contributions and through which they potentially reveal themselves. The receiver understands as much of this as he is ready to, but it seems always more than the communicant advertently intended. Just as the

communicant communicates, so the receiver perceives through a configuration of many functions. What is important is that he understands more than he is aware of, just as the communicant reveals more than he is aware of. What he understands but is not aware of is his "latent response" to the communication. He may or may not eventually become fully aware of all that he understands, but his psychic cathexes are redistributed and his potentialities for action changed much more than he is aware of at a given moment. The following case demonstrates the nature of the latent response and that it is on the basis of the latent response that the receiver relies on the future to rearrange the past into new components of noise and information. It also shows how in the mind, information does not "exist"; it "becomes."

A man who was courting a widow tried to curry her favor by lavishing attention on her children and her dog. He frequently stated with apparent sincerity, "I love children and dogs." The widow's manifest response was to think, speak, and act with conscious intent as though she accepted his manifest communication at face value. But along with the latter she received an impression which was not yet a manifest response. She noticed that his voice had a peculiar tone when he made this declaration. This tone was "noise" in many senses of the word. It was not intended, it communicated no information about his love (at the time), it was a vibration of the "machine" which made his words less clear, and it was disturbing. On one occasion, she observed him (without his knowledge) snarling at a child, and on another occasion kicking a dog. On each of these occasions an interesting event took place: A lot of "noises," of whose value and import the widow was not previously aware and which she had never intended to notice, were suddenly integrated so that her attention was adverted to them and they became informative: "He was lying *all along* when he said he loved children and dogs." The wooer's manifest communication had carried with it some latent communications. These activated in the widow a fund of inadvertent latent responses which led to her feeling of uneasiness. When his insincerity became manifest, her stored-up latent responses became manifest to her. While they were still latent, however, they were understood in the sense that they changed her potentialities for action so that, without precisely knowing why or consciously planning to, she maintained a certain reserve and spied upon him a little.

This example attempts to demonstrate why certain responses are called "latent" and why such latent influences are called "responses." The distinction between latent responses and latent content must now be discussed. A young scientist was greatly interested in the very subject discussed here: the relationship between cybernetics and psychology. He maintained that his ideas on the subject were objective, and on the surface they appeared so, but it soon became evident that he had a response of which he was not aware, to the problem. He became very defensive when the inclusion in his discussion of a certain quotation was questioned, a remark of O'Brien's in Orwell's *1984*: "Do you suppose our mathematicians are unequal to that?" It soon appeared that the literature he had read on communication theory had made him uneasy, so that quite unconsciously he had developed a hostile attitude, for he feared that further progress in the subject would reduce the esthetic values in human society. His latent response to the manifest and latent communications of the mathematicians was highly charged with resentment toward them. But the latent content of his hostility referred to something far in the past: his fear that his very conscientious ("mathematical") father would deprive him of the pleasure of having romantic ("esthetic") fantasies about his mother. He had a latent response (which became manifest in analysis) about the mathematicians, based on latent content about himself.

A woman reported: "I dreamed about a kitten." Both her latent communication, and the latent response in the analyst's mind were, as they both discovered later, something about a miscarriage, although at the time they talked about cats. The latent content in her mind, which determined her latent communication, was about herself, and the analyst's latent response was also about her and not about himself. In general, latent content refers to the latent perception of what concerns the individual's own psychology; latent response refers to the latent perception through communication of someone else's psychology, or, more broadly, to the latent perception through communication of something about external reality. Doubtful cases are taken care of in a formal way by defining communication as an understood emission of energy which affects the organism. The psychiatrist's latent response in clinical communication is usually a response to: the patient's latent response to a previous communication, plus the patient's latent con-

tent. For example: "This patient doesn't know that he is angry at what I said, which reminds him of earlier experiences; is that why I'm being unusually careful of what I say? And conversely for the patient sometimes, *mutatis mutandis*. For example: "The doctor doesn't know that he is responding to my provocation because of his earlier experiences; is that what I have to settle with him?"*

The concept of the latent response may now be recognized as having some familiar connotations. In clinical practice it refers to the latent communication of the subconscious reactions of the patient to his situation and to the subconscious perception of these reactions by the analyst, ideally without any interference from his own anxieties. In other words, it applies in this situation mainly to the perception of the transference reactions with a minimum of interference from counter-transference or anxiety, excluding what the analyst is able to verbalize to himself immediately. The peculiar skill of the analyst in this respect is to be able to detect more than is ordinarily detected of the latent communication. This skill comes through training in detecting his own latent responses and in purifying them by segregating the latent thoughts caused by counter-transference and anxiety. This is not meant to imply that there is necessarily a one-to-one relationship between a manifest communication and a manifest response, or between a latent communication and a latent response, although there is an empirical relationship.

Another familiar aspect of the latent response is its relationship to the unconscious or preconscious perceptive ego, that is, to intuition. In other words, the latent response to a communication is the intuitive knowledge of the receiver. Intuition may be described as follows:[23] It is one part of a series of processes (a segment of an epistemological spectrum) which work above and below the

*The latent response may be represented by, but is not identical with, a preconscious stream of associations in the mind of the receiver. This stream of thoughts can sometimes be detected by introspection while listening. It may be more or less influenced by the latent content which the communication activates in the receiver and is usually a compromise formation of the two influences: the latent response and the latent content which the manifest and latent communications activate. Patients often seem to respond to this stream of associations, when it occurs, rather than to the manifest communications of the analyst. T. Reik, (Ref. 22a) offers some good examples of this preconscious phenomenon. He also describes excellently some latent responses, though not by that name (Ref. 22b). All this is difficult to state more simply because of the multiplicity of vectors.

level of consciousness in an apparently integrated fashion, with shifting emphasis according to special conditions. Intuition is knowledge based on experience and acquired through sensory contact with the subject by means of pre-verbal unconscious or preconscious functions, so that the intuiter at first cannot formulate to himself or others exactly how he came to his conclusions. This means that the individual can know something without knowing how he knows it. He may not even know what it is that he knows, but behaves or reacts in a specific way as if his actions or reactions were based on some special knowledge.* In fact, he may not even know that he knows something, yet behaves as if he did.[26]

The receiver may not be aware that anything has been communicated besides the manifest content; or, if he is, he may not know how the latent communication is conveyed. Nevertheless, the distribution of his psychic cathexes is changed so that he behaves or reacts as if he had some additional understanding.

It is interesting to note that, in general, women seem to be more aware of, and to place more value consciously on the latent communication than men. For example, they are more apt to be aware of being influenced to a greater degree by a man's mood, zeal, or tone of voice than by what he says. Many men prefer to think that they are primarily influenced by the manifest communication.

Summary

Psychological aspects of the mathematical concepts of "noise" and "information" are discussed. Although these concepts are now mathematically related to the second law of thermodynamics, their evaluation still involves psychological problems. The most important point in this respect is that it is "noise" and not "information" which signals the state of the machine itself. This introduces an apparent paradox in the study of communication when "noise" and "information" are defined from a psychological point of view.

An attempt is made to justify heuristically some important differences in communication theory between the mathematical (syntactic) and the psychological (pragmatic) points of view. The

*This is reminiscent of Schilder's statement regarding dogs: "It is also true that the sound which for the dog has become a promise that feeding will occur is no longer like any other sound. It has gone through many more constructive processes. For the dog the sound has the import of feeding." (Ref. 24.) Schilder epitomizes the situation when he speaks of the prior wordless state that every thought goes through before it is formulated. (Ref. 25.)

psychologist differs from the mathematician in considering: (1) that the notion of "a precise message" is psychologically inconceivable; (2) that the amount of potential psychological information increases rather than decreases with increasingly intense (intrinsic) noise; (3) that the future can be successfully called upon to influence the past.

In interpersonal communications, "noise" is of more value than "information," since in such cases it is of more value to the communicants to know about each other's states than to give "information" to each other. "Noise" carries latent communications from the communicant. Manifest and latent communications arouse latent responses in the receiver which are important to both parties and are of special interest to psychiatrists.

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Carmel, Calif.

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A THREE-YEAR FOLLOW-UP STUDY OF NONCONVULSIVE HISTAMINE BIOCHEMOTHERAPY, ELECTRIC CONVULSIVE POST-HISTAMINE THERAPY, AND ELECTRIC CONVULSIVE THERAPY CONTROLS

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In a series of previous communications, the following aspects of the role of histamine in psychiatry have received extensive discussion:

1. The possibility of histamine liberation in tissues by the passage of an electric current of the intensity used in electric convulsive therapy (ECT).[1]

2. The possibility of histamine being a naturally occurring body hormone, having broad physiologic significance. It has been implicated negatively in the hypochlorhydria of psychosis[2] and positively in the stimulation of gastric hydrochloric acid secretion following electric convulsive therapy[3] and also perhaps during insulin therapy of psychotics.[4]

3. The use of histamine as an effective biochemotherapeutic agent in psychosis,[5-10] and the additional beneficial effect when used in combination with ECT[11-14] or insulin subcoma.[15-19]

4. The technic of its use, with indications and contraindications.[20]

5. Analysis of the nature of improvement, psychiatrically and psychologically, attending its use.[1, 21]

6. The physiologic denominators it has in common with other therapeutic modalities.[22]

7. Its place in a battery of biochemotherapeutic agents whose employment serially promises to increase the discharge rate from mental hospitals.

8. Its possible physiologic role in the interrelationship of the various hormones.[23, 24]

9. Finally, the broader implications to biology which its advent has brought forth leading to the development of a unifying concept regarding the etiology and pathogenesis of the psychoses and the psychoneuroses, providing a logical interpretation of pathogenesis in neuroendocrinologic terms.[23, 24]

*Deceased.

Scope of the Present Study

The scope of the present report will be:

I. An analysis of historical factors of 63 Creedmoor (N. Y.) State Hospital patients who comprised the clinical population of an experimental histamine therapy and control ECT study which was previously reported;[5, 11]

II. An examination of the untoward reactions, morbidity and mortality; and

III. A presentation of the three-year follow-up of the foregoing patients.

I. *Historical Factors*

Data as to the previous history of the patients under study have been collated and studied under two major points:

A. Whether any of the groups under study had a high percentage of patients who had achieved convalescent status following therapy during prior hospitalizations and thus might be more likely to yield a higher rate of convalescent status.

B. Whether the groups were comparable as to duration of hospitalization prior to test therapy.

II. *Untoward Reactions, Morbidity and Mortality*

A review of the side reactions encountered during therapy has been undertaken as well as a study of the clinical record of patients who died during the follow-up period.

III. *Three-Year Follow-Up*

The course of the patients in the three-year follow-up period following termination of therapy has been reviewed to determine the following eight points:

A. Whether patients who had achieved some immediate improvement short of convalescent status during the therapy and arbitrary observation period of five weeks, continued their improvement to the attainment of convalescent status thereafter.

B. Whether patients who had not shown improvement during the period of the study subsequently attained convalescent status *without* further treatment.

C. Whether the inclusion of patients who had received treatment after the test therapies and had attained convalescent status in the subsequent three years significantly affects the evaluation of the therapeutic efficacy of the different test regimens.

D. Whether patients, previously unimproved after electric convulsive therapy (ECT) given during the same hospitalization as, but prior to, the study, were refractory* to histamine therapy (HT) or post-histamine-ECT.

E. Whether histamine pre-treatment reduced the number of electric convulsive treatments required subsequently.

F. Whether the time required to attain convalescent status differed for the therapies studied.

G. Whether there was a difference in the relapse rate among the three groups.

H. The present-day status—approximately three years after therapy—of the 63 patients in both the experimental and control groups.

Clinical Material

The 63 female patients who received the therapeutic regimen under study, fall into the following groups (see Table 1):

There were 38 in the original Histamine Group.

Twenty-five patients, from among the 33 of this group who did not attain convalescent status on a single course of histamine, received ECT and constituted the Post-Histamine-ECT Group.

Twenty-five patients comprised the Control ECT Group.

The psychiatric disorders represented in these groups, age distribution, and length of hospital residence prior to the therapy were analyzed and charted in two preceding papers.[5, 11]

I. *Historical Factors*

A. *Was any one of the test groups, though chosen at random, weighted with patients who were more likely than the average to respond to any therapy as evidenced by attaining convalescent status during previous hospitalization?*

The Post-Histamine-ECT Group included patients 53 per cent of whom had achieved convalescent status at some time prior to the test therapies. The Control ECT Group had 46 per cent of prior convalescences. The combined HT and Post-Histamine-ECT Group of 38 patients showed convalescent status achieved by 45 per cent at some time prior to the test; the final HT group of

*Patients were designated refractory if they did not attain convalescent status after one course of HT with improvement starting either during four weeks of therapy or within one week following its termination.

Table 1. Improvement and Convalescent Status Rates During Test Period by Treatment Group and Diagnostic Category

Groups and Diagnostic Categories	No.	Improved*		Convalesent status	
		No.	Per cent	No.	Per cent
Histamine	38	10	26	5	13
Schizophrenic	(30)	(7)	(23)	(3)	(10)
Catatonic	21	5	24	1	5
Paranoid	9	2	22	2	22
Manic-depressive	(6)	(3)	(50)	(2)	(33)
Manic	5	2	40	1	20
Mixed	1	1	100	1	100
Involutional paranoid	(2)	(0)	(0)	(0)	(0)
Post-Histamine-ECT	25	12	48	4	16
Schizophrenic	(21)	(9)	(43)	(2)	(10)
Catatonic	16	9	56	2	13
Paranoid	5	0	0	0	0
Manic-depressive	(2)	(2)	(100)	(1)	(50)
Manic	2	2	100	1	50
Involutional paranoid	(2)	(1)	(50)	(1)	(50)
Control ECT	25	6	24	3	12
Schizophrenic	(23)	(4)	(17)	(2)	(9)
Catatonic	12	2	17	1	9
Paranoid	8	2	25	1	13
Hebephrenic	3	0	0	0	0
Manic-depressive	(2)	(2)	(100)	(1)	(50)
Combined Histamine and Post-Histamine-ECT	38	19	50	9	24
Schizophrenic	(30)	(13)	(43)	(5)	(17)
Catatonic	21	11	52	3	14
Paranoid	9	2	22	2	22
Manic-depressive	(6)	(5)	(83)	(3)	(50)
Manic	5	4	80	2	40
Mixed	1	1	100	1	100
Involutional paranoid	(2)	(1)	(50)	(1)	(50)

*Improved refers to all patients who either went on to convalescent status or were benefited to some degree by therapy.

Per cent is presented for ease of reference only.

13 patients—20 per cent. From the point of view of this one factor alone, therefore, the two main groups, the combined Histamine and Post-Histamine-ECT Group, and the ECT Control Group, are comparable. See Table 2.

Table 2. Number of Patients in Each Group Treated Prior to Test Period and Number Who Achieved Convalescent Status Prior to Test Period

Group	(No.)	Total No. treated some time prior	No. patients achieving convalescent status	Therapy prior hospital.	No. attain. C. S.	Previous therapy current hospital.	No. attain. C. S.
Histamine	(13)	5	1 (20%)	2	1 (a)	4	0
Post-Histamine-ECT ...	(25)	17	9 (53%)	5	4 (b)	15	6 (d)
Combined (1 and 2)...	(38)	22	10 (45%)	7	5	19	6
Control ECT	(25)	13	6 (46%)	2	2 (c)	12	5 (e)

(a) Treated with metrazol. (b) Insulin and ECT—2; Insulin—1; Hydrotherapy and ECT—1. (c) Insulin—1; ECT—1. (d) Metrazol—1; ECT—4; Hydrotherapy and ECT—1. (e) ECT—4; Narcosynthesis—1.

B. *Were the three groups comparable as to the duration of hospitalization up to the administration of the test therapy?*

It can be readily seen from Table 3 that the experimental groups had more patients with shorter duration of hospitalization in the past than those in the ECT Control Group.

Table 3. Duration of Hospitalization Prior to Test Therapy and Attainment of Convalescent Status Immediately After Therapy (Percentages are given for ease of reference)

No. of patients	a. HT 13+25=38	b. Post-HT-ECT 25	c. ECT control 25	a (13) and b (25) combined report 38
6 mos. or less hosp.	19 (50%)	13 (52%)	7 (28%)	19 (50%)
Attained conv. status	4 (21%)	2 (15%)	1 (14%)	6 (32%)
6 mos. or more hosp.	19 (50%)	12 (48%)	18 (72%)	19 (50%)
Attained conv. status	1 (5%)	2 (17%)	2 (11%)	3 (16%)
Total immed. conv. status	5 (13%)	4 (16%)	3 (13%)	9 (24%)

However, a surprising fact is disclosed. On the basis of a higher convalescent status rate in the patients with shorter duration of hospitalization, as revealed by these data, one would have been led to expect that the ECT Control Group would not equal the Test Therapies Group in the prior rate of convalescent status. Yet this equality was indeed the case, as was shown in Table 2. Regardless of any statistical explanation, the presence of a larger proportion of patients with shorter periods of hospitalization in the Test Ther-

apies Group may be a weakness and should be avoided in future comparative studies. However, it is interesting to note that the outcome in the ECT Control Group was not significantly better in patients with short durations of hospitalization (1 of 7 = 14 per cent) than in those over six months (2 of 18 = 11 per cent). Without denying the role of this factor in the effect achieved, one can safely assume that it was not sufficient to negate the significance of the results obtained.

II. *Untoward Reactions, Morbidity and Mortality*

Aside from the transient vascular response—a marked drop in systolic and diastolic pressure accompanied by tachycardia and flushing of face, arms and other parts of the body—no harmful effects could be attributed to the utilization of histamine in the manner described. However, during the three-year follow-up period, five patients of the 63 in the entire series, three in the experimental groups and two in the ECT Control Group, died. It seemed advisable to analyze the deaths to ascertain if there might be any relationship to therapy. Two of the three in the experimental groups were in the HT group and one in the Post-HT-ECT group.

Postmortem examination was carried out in only one of the patients (Post-HT-ECT, No. 25) by the medical examiner following a sudden death. A second sudden death (HT, No. 6) was not accepted by the medical examiner's office for necropsy. Of the other three patients, one (ECT No. 23) was a suicide and two (ECT No. 20 and HT No. 4) died after chronic illnesses. The case histories are summarized below:

Case 1. HT, No. 4, aged 38 at death; final diagnosis: chronic myocarditis, dementia præcox. This patient was extremely undernourished and emaciated upon admission to the hospital. During a previous hospitalization abroad, she had had insulin coma therapy. She was admitted to Creedmoor State Hospital on August 14, 1945. At this time, physical examination revealed only a poor nutritional status. In December 1945 the patient developed a right lower lobe pneumonia which responded to chemotherapy. Frequent feedings were given in order to achieve weight gain. Histamine therapy was instituted January 17, 1946 in an attempt to alleviate mental symptoms and was discontinued February 7, 1946. The next month, the patient was eating well and showed

some improvement following therapy. An x-ray plate taken March 22, 1946 was reported as showing both hilar shadows "moderately increased in size and density with evidence of fibro-calcified deposits. Linear pulmonic markings are accentuated in both lung fields due to chronic bronchitis. Apices and costophrenic angles are clear."

The following month, the patient was reported to be progressively weaker. She had developed a large abscess, which required incision, in the right buttock. Following transfer to the medical and surgical pavilion, she continued her downhill course. The terminal note stated that the patient had cyanosis, dyspnea and rapid pulse. She died on May 18, 1946—three months after termination of histamine therapy. Permission was not granted for autopsy and the patient was certified as having died of chronic myocarditis and dementia præcox.

COMMENT: Since this death occurred three months after the discontinuance of histamine therapy, it is surely not attributable to acute histamine toxicity. It is unfortunate, however, that an autopsy was not available in this case to check particularly on the myocardial damage. However, it is important to note that the clinical findings did not implicate the heart prior to the terminal state.

Case 2. HT, No. 6, aged 26 at death; final diagnosis: dementia præcox, catatonic type, 10 years; and acute excitement, two days. This patient was admitted on October 14, 1944. HT was begun January 17, 1946 and terminated February 8, 1946. ECT was administered from April 15, 1946 to July 22, 1946, for a total of 32 grand mal convulsions. Thereafter, she received ECT on occasion, as deemed necessary, totaling 45 convulsions. The last convulsive treatment was given on July 9, 1947. On August 7, 1947, at 2:30 a. m., after two days of acute excitement, she was observed to be cyanotic. Her pulse was weak and there was no evidence of injury. Her temperature was 99.8. The patient died at 4:30 a. m. The medical examiner waived autopsy and in the absence of consent, it was not performed by the hospital staff.

COMMENT: Here again, it is difficult to relate the death of the patient to prior therapy. Histamine treatment had been completed six months previously, electric convulsive therapy one month pre-

viously—both without evident incident or disturbance. Acute excitement was the only untoward event directly preceding the mortality.

Case 3. Post-HT-ECT, No. 25, aged 35 at death; final diagnosis: aspirated stomach contents into lungs, asphyxia; schizophrenia. This patient was admitted October 25, 1944. HT was instituted January 15, 1946 and ECT was administered between February 9, 1946 and March 9, 1946, for a total of 23 grand mal convulsions and 1 petit mal reaction. Subsequently, beginning August 19, 1946, and until November 20 of the same year, the patient had ECT, 19 convulsions. On November 25, 1946 she was found in a comatose state from which she could not be aroused and died one hour later.

COMMENT: The certified diagnosis of asphyxia caused by aspiration in this case was based on the pathological findings of a postmortem examination by the medical examiner.

Case 4. ECT, No. 20, aged 22 at death; final diagnosis: pulmonary abscess, dementia præcox, hebephrenic type. This patient was admitted September 15, 1945. She was included in the ECT-Control Group and received a course of 21 grand mal convulsions between March 15, 1946 and May 8, 1946 without improvement. Between July 10, 1946 and May 22, 1947, she received additional ECT, 44 convulsions, without improvement.

On March 5, 1947, during the period of another course of ECT, the patient was x-rayed because of a left lower lobe pneumonia diagnosed on physical examination. The roentgenologist reported "an area of infiltration at left base suggesting acute pneumonia." On April 7, 1947, a second x-ray was negative. However, the patient later developed fever again, and an x-ray on June 9, 1947 revealed "consolidation of the left central and left lower lung fields suggesting a possible pneumonia." On June 25, 1947 there was no change in radiological findings. The following week, it was decided to treat the patient as a case of lung abscess. She maintained an elevated temperature and appeared acutely ill in spite of penicillin therapy. An x-ray on July 14 showed "an increase in consolidation of left lower lung field." By the following week, the patient had become productive of large amounts of foul sputum necessitating postural drainage. She continued progressively downhill and died on August 4, 1947 following a violent coughing paroxysm. An autopsy could not be performed.

COMMENT: The possibility cannot be excluded that, sometime during her second ECT course, this patient aspirated a foreign body and developed a lung abscess, although no indication of such an occurrence was noted in the chart.

Case 5. ECT, No. 23, aged 34 at death; final diagnosis: manic-depressive, depressed; suicide seven months after discharge. This patient was admitted December 22, 1945. She was given ECT as one of the ECT Control Group between March 20, 1946 and March 27, 1946 with marked improvement. Convalescent status was granted May 25, 1946 and she was discharged the following year. On December 21, 1947 she committed suicide.

III. *Three-Year Follow-Up*

In preparing this study, criteria previously defined[1, 2] were applied unless otherwise stated in the corresponding section under review. These were: (1) Improvement must have been attained during the four weeks of therapy or within one week after termination of therapy; and (2) convalescent status, i. e., sufficient recovery to warrant release by the hospital staff, was usually accompanied by elimination of the major presenting symptomatology.

During the follow-up period, the patients were dispersed to different wards and different services, in the usual course of the hospital's routine, and thus all patients were subject to similar random chances. The therapeutic procedures applied and observations made during this period were those usual for the hospital.

A. *Did patients who had achieved some immediate improvement during the test period, continue improving until they attained convalescent status?*

Convalescent status was attained by five additional patients who had previously been considered as only improved during or within one week following termination of the therapy but who had received no further treatment. These patients had been previously classified merely as benefited because the arbitrarily set "experimental period" had terminated. Since these results were probably related to therapy, the data are herewith included, necessitating correction of the original figures.

I. Histamine Group.*

Improvement—54 per cent.**
Convalescent status—38 per cent, now corrected to 46 per cent because of an additional case:

HT, No. 2, a manic-depressive, manic, aged 40, with a hospital residence of nine years,† received 26 histamine treatments over a period of 49 days, with immediate improvement, and ultimately achieved convalescent status nine months after termination of HT.

II. Post-Histamine-ECT Group.

Improvement—48 per cent.
Convalescent status—16 per cent, now corrected to 28 per cent because of three additional cases:

(a) Post-HT-ECT, No. 5, a catatonic schizophrenic, aged 24, with a hospital residence of two months, improved with 26 ECT and 73 HT treatments in a period of 128 days and achieved convalescent status two months after termination of the combined therapies.

(b) Post-HT-ECT, No. 16, a catatonic schizophrenic, aged 44, with a hospital residence of six months, improved following 24 grand mal seizures and one petit mal seizure (ECT), and 48 histamine treatments, all over a period of 73 days. She achieved convalescent status three and one-half months after termination of therapy.

*For purposes of the three-year follow-up study, the HT Group has been limited to the 13 patients who had HT only during the test period.

**The results when calculated on the basis of all 38 patients in the original Histamine Group would show the following immediate results and subsequent results without therapy: §

	Immediate	A. Corrected by improved patients who subsequently attained convalescent status without further therapy	B. Corrected by unimproved patients who subsequently improved and attained convalescent status without further therapy
	Per cent	Per cent	Per cent
Improvement	26	26	32
Convalescent status (C. S.)	13	16	21

†Hospital residence is calculated from admission to the date of administration of test therapy to the patient.

(c) Post-HT-ECT, No. 16, a manic-depressive, manic, aged 34, with a hospital residence of one year and 10 months, improved with 14 electric convulsive treatments and 45 histamine treatments in a period of 56 days, and achieved convalescent status four months after termination of therapy.

III. Control ECT Group.

Improvement—24 per cent.

Convalescent status—12 per cent, now corrected to 16 per cent because:

(a) ECT, No. 7, a manic-depressive, mixed, aged 41, with a hospital residence of three years, two and one-half months, improved with 19 electric convulsive treatments in a period of 57 days and achieved convalescent status three months after termination of therapy.

IV. Histamine and Post-Histamine-ECT Groups Combined.

Improvement—50 per cent.

Convalescent status—24 per cent, now corrected to 34 per cent.

COMMENT: The writers believe that the convalescent status results originally reported as immediate, following an arbitrary period of four weeks of the test therapies, should now be adjusted to include those patients who improved in the study and then subsequently continued to convalescent status without further therapy. Their inclusion is in accord with the original criterion, because improvement had started during the arbitrary period of four weeks of therapy and one week beyond its completion, and the eventual attainment of convalescent status can thus be assumed to be related to the test therapy applied.

Inclusion of the five patients in this category of delayed convalescent status (HT Group, 1; Post-Histamine-ECT Group, 3; and ECT Control Group, 1) raises the convalescent status rate of the Post-Histamine-ECT Group from 16 per cent to 28 per cent—or almost double that of the ECT Control Group, 16 per cent; while the HT and Post-Histamine-ECT Groups combined had a convalescent status rate of 34 per cent, or more than double the 16 per cent ECT Group rate. The entire original HT Group of 38 patients (computing only the results of HT alone) and the ECT Control Group of 25 patients showed approximately the same rates, each 16 per cent.

B. *Did patients who had not evidenced gross signs of improvement during the test period subsequently attain convalescent status without further treatment?*

Convalescent status was subsequently achieved by four patients who had *not* shown any striking benefit from the test therapies and who had *not* received further treatment. These results may or may not have been related to therapy, but the inclusion of this group as having actually benefited would bring about the following percentile changes:

I. Histamine Group.

Improvement—69 per cent (from 54 per cent).
Convalescent status—46 per cent, now corrected to 62 per cent because:

(a) HT, No. 3, a paranoid schizophrenic, aged 37, with a hospital residence of five years, eight months, received 11 histamine treatments without improvement over a period of 10 days and subsequently achieved convalescent status 13 months after the termination of therapy.

(b) HT, No. 9, a manic-depressive, manic, aged 26, with a hospital residence of one year, one month, received nine histamine treatments over a period of 11 days without improvement and subsequently achieved convalescent status four months after termination of the therapy.

II. Post-Histamine-ECT Group.

Improvement—52 per cent (from 48 per cent).
Convalescent status—28 per cent, now corrected to 32 per cent because:

Post-HT-ECT, No. 17, a paranoid schizophrenic, aged 38, with a hospital residence of 11 months, was unimproved after seven electric convulsive treatments and 70 histamine treatments, in a period of 146 days; she achieved convalescent status one month after termination of therapy.

III. Control ECT Group.

Improvement—28 per cent (from 24 per cent).
Convalescent status—16 per cent, now corrected to 20 per cent because:

ECT, No. 16, a catatonic schizophrenic, aged 36, with a hospital residence of one year, two months, was unimproved after 19 electric convulsive treatments in a period of 54 days but subsequently achieved convalescent status two years after termination of therapy.

IV. Histamine and Post-Histamine-ECT Groups Combined.

Improvement—56 per cent (from 50 per cent).

Convalescent status—34 per cent, now corrected to 42 per cent.

COMMENT: Since improvement after ECT may begin later than one week following termination of treatment, the inclusion of such results was considered advisable in the comparative rating. Accordingly, the data previously revised under the preceding observation, were again adjusted for four patients who subsequently achieved convalescent status. Of these, two were in the HT Group and one each in the other two groups.

In the comparative ratings, the Post-Histamine-ECT Group remained ahead of the ECT Control Group in the attainment of convalescent status—32 per cent, as compared to 20 per cent, whereas the rate of 21 per cent of the original Histamine Group of 38 patients (results from HT alone) was essentially not different from that of the control group.

C. *Did patients who received additional treatment, after conclusion of the test therapy and the immediate follow-up, attain convalescent status in the subsequent three years, thereby affecting the evaluation of therapeutic efficacy of the different regimens studied?*

In the subsequent three years 12 more patients left on convalescent status after receiving additional therapy.*

I. Histamine Group.

Improvement—77 per cent (from 69 per cent).

Convalescent status—62 per cent, now corrected to 69 per cent because:

HT, No. 13, a catatonic schizophrenic, aged 23, with a hospital residence of 10 and one-half months, unimproved after 31 histamine treatments over a period of 23 days, subsequently achieved convalescent status 11 months after the start of HT, and three months after the termination of an additional course of 32 electric convulsive treatments.

*Additional therapy was ECT in every case except one, in which it was hydrotherapy.

II. Post-Histamine-ECT Group.

Improvement—64 per cent (from 52 per cent).
Convalescent status—32 per cent, now corrected to 60 per cent because:

(a) HT-ECT, No. 12, a catatonic schizophrenic, aged 29, with a hospital residence of one month, improved on 10 electric convulsive treatments and 18 histamine treatments, in a period of 43 days. She achieved convalescent status six and one-half months after the start of HT and four days after the termination of 10 additional electric convulsive treatments.

(b) HT-ECT, No. 4, a catatonic schizophrenic, aged 22, with a hospital residence of one month, improved on 42 grand mal and one petit mal electric convulsive treatments, after 50 histamine treatments in a period of 117 days. She achieved convalescent status five months after the start of HT, following hydrotherapy.

(c) HT-ECT, No. 3, a catatonic schizophrenic, aged 22, with a hospital residence of one month, improved on 24 electric convulsive treatments after 28 histamine treatments in a period of 142 days. She achieved convalescent status nine and one-half months after the start of HT and one month after the termination of 35 additional electric convulsive treatments.

(d) HT-ECT, No. 20, a catatonic schizophrenic, aged 41, with a hospital residence of three and one-half months, was unimproved by 14 grand mal and two petit mal electric convulsive treatments after 11 histamine treatments in a period of 50 days. She subsequently achieved convalescent status a year after the start of HT, and four months after termination of 15 additional electric convulsive treatments.

(e) HT-ECT, No. 2, a catatonic schizophrenic, a postpartum case, aged 30, with a hospital residence of four months, improved on nine grand mal and one petit mal electric convulsive treatments after 45 histamine treatments in a period of 56 days. She subsequently achieved convalescent status one year after the start of HT and two months after the termination of 52 additional electric convulsive treatments.

(f) HT-ECT, No. 8, a catatonic schizophrenic, aged 34, with a hospital residence of three years, was unimproved by 18 grand mal and one petit mal electric convulsive treatments and 30 histamine treatments in a period of 178 days; but subsequently achieved convalescent status nine months after the start of HT and immediately after the termination of 19 additional electric convulsive treatments.

(g) HT-ECT, No. 9, an involutional paranoid patient, aged 50, with a hospital residence of four years and five months, was unimproved by 14 grand mal and five petit mal electric convulsive treatments and 39 histamine treatments in a period of 124 days; but she subsequently achieved convalescent status one year and five months after the start of HT, and following more than 17 additional electric convulsive treatments.

III. Control ECT Group.

Improvement—44 per cent (from 28 per cent).
Convalescent status—20 per cent, now corrected to 36 per cent because:

(a) ECT, No. 19, a catatonic schizophrenic, aged 22, with a hospital residence of one month, was unimproved by 14 electric convulsive treatments in a period of 40 days, but subsequently achieved convalescent status two years and two months after the start of therapy and four months after an additional 135 electric convulsive treatments.

(b) ECT, No. 9, a catatonic schizophrenic, aged 27, hospitalized for two months, was unimproved by 20 electric convulsive treatments in a period of 75 days. She subsequently achieved convalescent status nine months after the start of therapy and one and one-half months after the termination of 40 more electric convulsive treatments.

(c) ECT, No. 8, a catatonic schizophrenic, aged 29, a postpartum case, with a hospital residence of one year and four months, was unimproved by 17 electric convulsive treatments in a period of 45 days, but subsequently achieved convalescent status nine months after the start of therapy and two months after termination of an additional course of 34 electric convulsive treatments.

(d) ECT, No. 25, a paranoid schizophrenic, aged 19, with a hospital residence of one month, was unimproved by 20 elec-

Table 4. Improvement Rates and Convalescent Status Rates

Group		Immediate				Including A.				Including B.				Including C.			
		Improved		C. S.		Improved		C. S.		Improved		C. S.		Improved		C. S.	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
(Histamine)*	(38)	(10)	(26)	(5)	(13)	(10)	(26)	(6)	(16)	(12)	(32)	(8)	(21)				
Histamine	(13)	7	54	5	38	7	54	6	46	9	69	8	62	10	77	9	69
Post-Histamine-ECT	(25)	12	48	4	16	12	48	7	28	13	52	8	32	16	64	15	60
Control ECT	(25)	6	24	3	12	6	24	4	16	7	28	5	20	11	44	9	36
Combined Histamine and Post-Histamine ECT	(38)	19	50	9	24	19	50	13	34	22	58	16	42	26	68	24	63

A.—Patients who showed immediate improvement and subsequently attained convalescent status *without* further treatment.

B.—Patients who had not evidenced gross signs of improvement during or within one week after test therapy but subsequently attained convalescent status *without* further treatment.

C.—Patients who after receiving further treatment—ECT in all but one case—subsequently attained convalescent status.

*—38 patients in original Histamine Group.

tric convulsive treatments in a period of 48 days, but subsequently achieved convalescent status four and one-half months after the start of therapy and one and one-half months after termination of an additional 10 grand mal and one petit mal electric convulsive treatments.

IV. Histamine and Post-Histamine-ECT Combined.

Improvement—68 per cent (from 56 per cent).

Convalescent status—42 per cent, now corrected to 63 per cent.

The data in reply to questions A, B and C are summarized in Table 4.

D. *Were patients previously unimproved by ECT (during the hospitalization of the test period) also refractory to HT or Post-Histamine-ECT?*

Patients who previously had been refractory to ECT were not necessarily refractory to HT or to post-histamine-ECT. Convalescent status was attained by five of eight such patients after HT or post-histamine-ECT was administered. Of these five, one received no further therapy, and four received subsequent ECT after termination of the test period. Of four patients, in the Control ECT Group, who were previously refractory to this therapy, one, after no immediate improvement, achieved convalescent status two years later. Thus, previous refractoriness to ECT might have been broken in a few cases by the course of HT or might have yielded to a spontaneous remission.

(a) HT, No. 8, a paranoid schizophrenic, aged 33, with a hospital residence of four months, was unimproved following ECT, 12 grand mals and 2 petit mals, received HT alone with improvement within a week following therapy, and achieved convalescent status six months after the start of HT. The patient returned 31 months later and again attained convalescent status after four months without further therapy.

(b) HT, No. 13, a catatonic schizophrenic, aged 23, with a hospital residence of 10 and one-half months, was unimproved following ECT (40 grand mals and three petit mals) and HT alone. She received a subsequent ECT course of 32 grand mals and achieved convalescent status 11 months after the start of HT.

(c) HT-ECT, No. 2, a catatonic schizophrenic, a post-partum patient, aged 30, with a hospital residence of four months, was unimproved following ECT (14 grand mals and one petit mal). She was benefited on post-histamine-ECT, received a subsequent ECT course of 52 grand mals, and achieved convalescent status 12 months after the start of HT.

(d) HT-ECT, No. 9, an involutional paranoid patient, aged 50, with a hospital residence of four years and five months, was unimproved following prior ECT (10 grand mals and 10 petit mals) and post-histamine-ECT. She received a subsequent ECT course of 12 grand mals and five petit mals and achieved convalescent status 17 months after the start of HT.

(e) HT-ECT, No. 20, a catatonic schizophrenic, aged 41, with a hospital residence of three and one-half months, was unimproved following prior ECT (seven grand mals and seven petit mals) and 11 histamine treatments. She remained unimproved on ECT (14 grand mals and two petit mals), achieving convalescent status 12 months after the start of HT, four months after termination of 15 grand mal electric convulsive treatments.

COMMENT: Evaluation of the results of all patients, including those who received further therapy, was undertaken to determine whether subsequent events altered the relative benefits of the procedure studied. No alteration was found.

Twelve patients achieved convalescent status following additional therapy—which in every case but one (hydrotherapy) was ECT. Of these, one was in the HT Group, seven in the Post-Histamine-ECT Group and four in the ECT Control Group. Thus, in the Post-Histamine-ECT Group 64 per cent showed improvement, and 60 per cent attained convalescent status; while in the ECT Control Group, 44 per cent showed improvement, and 36 per cent attained convalescent status.

The results analyzed here seemed to point strongly to an added advantage conferred by HT. Not only was it effective by itself, but also it seemed to have a potentiating effect on ECT, resulting in a far greater percentage of improved and convalescent status patients when given combined with ECT. In addition, it appeared that patients previously unimproved after ECT during the hospitalization of the test period, did not necessarily fail to respond

to either HT or Post-Histamine-ECT. On the contrary, they seemed to be assured a better response following HT and fared five times better than patients who received additional ECT without histamine. (See Table 5.)

Furthermore, study of the effect of additional courses of ECT on patients previously refractory to this therapy—as in those unimproved in the ECT Control Group—revealed that of 18 patients, four (22 per cent) attained convalescent status. This does not compare favorably with the attainment of convalescent status by three of four patients in the Post-Histamine-ECT Group who were unimproved with prior ECT.

E. *Did histamine pre-treatment reduce the number of electric convulsive treatments required subsequently to achieve convalescent status?*

No definitive conclusion can be drawn from the results when they are analyzed to determine the number of electric convulsive treatments required for attainment of convalescent status. Therapeutic courses of eight patients (Post-HT-ECT, Nos. 1-8) were compared as to the numbers of convulsions required to attain convalescent status before histamine; with histamine; and after histamine. In addition, the therapy of two patients in the ECT Control Group and one in the Histamine Group was reviewed. Three of eight patients (Post-HT-ECT, Nos. 4, 5, 7) required fewer convulsions during or after the test period. (See Table 6.)

F. *Was there a difference in the time required by patients in each group to attain convalescent status?*

The time elapsing between the institution of test therapy and the attainment of convalescent status is presented in Table 7. The HT Group had patients leave on convalescent status four to four and one-half months after initiation of therapy, one month later than the other two groups. However, no definite conclusion can be drawn from so small a variation.

G. *Was there any difference in the relapse rate of the three groups?*

The courses of the patients in the three groups who achieved convalescent status following the test therapies are recorded in Table 8. Of five patients in the HT Group, three relapsed; and, of these, two again attained convalescent status; one with and one

Table 5. Effect of Histamine on Patients Previously Refractory to ECT; Comparison with Effect of Additional Course of ECT in Control Group

Group and patient	Diagnosis	Prior ECT, Current Hosp. G. M.	P. M.	Result Prior ECT	Test therapy		Result	Supplement ECT G. M.	P. M.	Result	No. Pts. Refrac. prior ECT	No. Pts. Attain. C. S.	No. Pts. Unimp.
Histamine-(HT)											4	2	2
H 6	S.—Cat.	21	..	U	HT		U	77	..	U	..	..	..
H 10	S.—Cat.	15*	..	U	HT		U	38	..	U	..	..	..
H 13	S.—Cat.	40	3	U	HT		U	32	..	CS	..	..	..
H 8	S.—Par.	12	2	U	HT		CS	..	..	..	..	..	..
Post-HT-ECT					G. M.	P. M.					4	3	1
HC 2	S.—Cat. (PP)	14	1	U	9	1	B	52	..	CS	..	..	..
HC 20	S.—Cat.	7	7	U	11	2	U	26	..	CS	..	..	..
HC 25	S.—Par.	37	10	U	23	1	U	19	..	U	..	..	..
HC 9	Inv. Par.	10+	10+	U	14	2	U	12	5	CS	..	..	..
ECT Control											4	1	3
C 4	S.—Cat.	15	1	U	8	..	U	191	..	U	..	..	..
C 5	S.—Cat.	..	..	U	6	..	U	125	..	U	..	..	..
C 16	S.—Cat.	20	..	U	19	..	U	..	..	CS**	..	..	..
C 14	S.—Par.	38	10	U	20	2	U	15	..	U	..	..	..

*Patient also had had 17 grand mal convulsions induced by metrazol.

**This patient was unimproved immediately after control ECT but subsequently improved and attained convalescent status two years later.

Group abbreviations:

H—Histamine (HT).
HC—Post-Histamine-ECT.
C—ECT control.
S.—Cat.—Schizophrenia, catatonic type.
S.—Par.—Schizophrenia, paranoid type.
Inv. Par.—Involutional psychosis, paranoid type.
G.M.—Grand mal.
P. M.—Petit mal.
PP—Postpartum.
U—Unimproved.
CS—Convalescent status.

without subsequent therapy. Of four patients in the Post-Histamine-ECT Group, three relapsed; and, of these, two again attained convalescent status with subsequent treatment; and one without it. None of the three patients in the ECT Control Group relapsed.

Table 6. Number of Grand Mal Convulsions Administered to Patients Achieving Convalescent Status Before, During and After Test Therapy Period

Group and Patient	No. G. M. Before Test Period → Conv. Status	No. G. M. During Test Period and Result	No. G. M. After Test Period → Conv. Status
Histamine			
1. H 13	**	—	32
Post-Histamine-ECT			
1. HC* 5	12	24 U	16+
2. HC 20	—	11 U	26
3. HC 2	—	9 U	32
4. HC 8	64	18 U	19
5. HC 14	10	8 CS	37‡
6. HC 17	19	7 U—CS†	—
7. HC 1	10	11 CS	9‡
8. HC 21	6***	2 CS	—
ECT Control			
1. C 10	8	17 CS	—
2. C 23	5	5 CS	—

*HC—Post-HT-ECT.

**Achieved CS on HT alone.

†Without further therapy. Improvement was noted more than one week after termination of treatments. Because of the criterion previously set, this patient was not included in the original group achieving convalescent status.

‡After relapse. U—unimproved.

***With insulin. CS—convalescent status.

Thus, there was a difference in the relapse rate of the patients in the three groups who immediately achieved convalescent status. The clinical course of some of the patients in the HT Group seemed to support an earlier observation on the possible need of maintenance histamine therapy in selected cases.* Although patients in the Post-Histamine-ECT Group who went on to convalescent status immediately following test therapy indicated the greatest likelihood to relapse, all of them subsequently did achieve "permanent" convalescent status. There were no relapses in the ECT

*This will be discussed more fully in subsequent papers on histamine therapy of non-hospitalized psychotics and psychoneurotics.

Table 7. Time in Months Required from Institution of Test Therapy to Attainment of Convalescent Status

Months	2-2½	3-3½	4-4½	5-5½	6-6½	9-9½	11-12	13-15	16-18	24-26	
Histamine (13 pts.)											
Test therapy	1	1	2		1						Conv.
Subsequent without therapy			1				1	1			status
Subsequent with therapy...							1				9 (69%)
Post-Histamine-ECT (25 pts.)											
Test therapy	2	2									Conv.
Subsequent without therapy					3						status
Subsequent with therapy...				1	2	2	1		1		14 (56%)
ECT Control (25 pts.)											
Test therapy	2	1									Conv.
Subsequent without therapy										1	status
Subsequent with therapy ...			1	1		2				1	9 (36%)

Control Group. The regrouping of the data relating to this aspect of the clinical course of the three groups of patients over the three-year period is included in Table 8.

Table 8. Course of Patients Who Attained Convalescent Status Immediately Following Test Therapy

Group	No. conv. status	No. relapsed	C. S. without subs. treatment	C. S. with subs. treatment	In hospital	"Permanent" C.S.
Histamine	5	3	1	1	1	4/5
Post-Histamine-ECT	4	3	1	2	0	4/4
ECT control	3	0	0	0	0	3/3

II. *What is the present-day status—three years after therapy —of the 63 patients in the experimental and control groups?*

At the end of the three-year period, of the 63 patients studied, 27 were out of the hospital, either on convalescent status or discharged. Of these: (a) Seven patients were from the Histamine Group of 13; (b) 14 were from the Post-Histamine-ECT Group of 25 (56 per cent); and (c) six were from the ECT Control Group of 25 (24 per cent).

The immediate and three-year follow-up status of all the patients and the relationship of attainment of convalescent status and duration of hospitalization are charted in Table 9.

It must again be noted that 42 patients had subsequently received therapy over the three-year period, while three patients of the HT Group, two of the Post-Histamine-ECT Group and three of the ECT Control Group maintained their status or regained it without further therapy. This also indicated better results with histamine either singly or in combination with other therapy.

Summary

The histories of 63 hospitalized female psychotics with schizophrenic, manic-depressive and involutional disorders—treated with histamine alone, histamine followed by ECT, and by ECT alone as a control group, are reviewed from the time of their first hospital admissions. A three-year follow-up on the subsequent course of the patients treated with histamine and Post-Histamine-ECT as well as the ECT control patients is presented. The findings revealed that:

1. The HT Group and Post-Histamine-ECT Group combined showed improvement in 68 per cent and convalescent status in 63 per cent, taking into account patients who subsequently attained improvement over the three-year period, either with or without further therapy. The ECT Control Group had improvement in 44

Table 9. Immediate and Three-Year Follow-up Status of 63 Patients in Test Groups: Histamine (HT), Post-Histamine-ECT and ECT Control

Therapy	a. HT	b. Post-HT-ECT	c. ECT Control	a. and b. Comb. Results
No. of patients	38—13*	25	25	38
1. Immediate C. S. and percentage	5 (13%)**	4 (16%)	3 (12%)	9 (24%)
Three-year Follow-up				
2. No. patients with 6 mos. or less hospitalization and percentage	6 (46%)†	13 (52%)	7 (28%)	19 (50%)
3. No. on C. S.	4	9	3	13
4. No. patients with over 6 mos. hospitalization and percentage	7 (54%)†	12 (48%)	18 (72%)	19 (50%)
5. No. on C. S.	3	5	3	8
6. Total No. patients out of hospital (inc. 3. and 5.) and percentage	7 (54%)†	14 (56%)	6 (24%)	21 (55%)

*The original group consisted of 38 patients, of whom 25 went on to ECT (b.) leaving a total of 13 patients who received HT alone.

**Calculated on the basis of the immediate group of 38 patients.

†Calculated on the basis of the resultant group of 13 patients.

per cent and convalescent status in 36 per cent; the Post-Histamine-ECT Group alone, showed improvement in 64 per cent and convalescent status in 60 per cent.

2. Patients previously refractory to ECT during the same hospitalization were found responsive to HT, Post-Histamine-ECT or to ECT alone. However, five of eight ECT refractory patients (63 per cent) in the combined test groups (HT plus Post-Histamine-ECT) attained convalescent status, with another course of ECT, whereas of four in the ECT Control Group, only one subsequently achieved convalescent status and did so two years later. Furthermore, of 18 patients previously refractory to ECT (in

prior admissions) in the Control Group, only four (22 per cent) finally attained convalescent status with a second course of ECT (Table 10).

3. Though the groups were comparable as to diagnostic classification, age groups, previous therapy and even prior attainment of convalescent status, *they were not wholly comparable as to duration of hospitalization.* The Control Group, on analysis, revealed a higher percentage of patients with over six months or one year of hospitalization. This is a weakness in the study which may not be significant since convalescent status in the ECT Control Group is approximately the same in those under and over six months of hospitalization (Table 11).

4. The HT Group had the highest relapse rate while the ECT Control Group had the lowest. This corroborated an earlier observation of the possible need for maintenance HT.

Table 10. Results of Subsequent Course of ECT in ECT Control Patients Refractory During Test Period

Patient number	Diagnosis	ECT Control			Subsequent ECT		
		G. M.	P. M.	Result	G. M.	P. M.	Result
C* 4	DPC	20**	..	U	179	..	U
C 5	DPC	17**	..	U	108	..	U
C 8	DPC, PP	17	..	U	34	..	CS
C 9	DPC	20**	..	U	40	..	CS
C 13	DPC	21**	..	U	33	..	U
C 19	DPC	14	..	U	135	..	CS
C 21	DPC	19**	..	U	19	..	U
C 22	DPC, PP	24	..	U	28	..	U
C 24	DPC	21**	1	U	17	..	U
C 1	DPP	35	..	U	5	..	U
C 2	DPP, PP	15	1	U	46	..	U
C 11	DPP	20**	..	B	60	..	U
C 14	DPP	20	2	U	15	..	U
C 15	DPP	18**	..	U	50	..	U
C 17	DPP	15	2	U	22	..	U
C 25	DPP	20	1	U	10	..	CS
C 18	DPH	23	..	U	44	..	U
C 20	DPH, PP	16	..	U	44	..	U

*ECT Control Group

**ECT Control course completed after termination of test period

B—Benefited
U—Unimproved
CS—Convalescent status

DPC—Schizophrenia, Catatonic
DPH—Schizophrenia, Hebephrenic
DPP—Schizophrenia, Paranoid
PP—Post-partum

Table 11

Duration of Hospitalization Prior to Test Therapy and the Achievement of Convalescent Status

In Patients Hospitalized Less or More Than 6 Months

	Histamine alone						Post-Histamine-ECT						ECT Control						Comb. HT plus Post-Histamine-ECT					
	No.	Immed. C. S.	B. ↑ C. S. with later Rx	U. ↑ C. S. with later Rx	C. S. with later Rx	Total C. S.	No.	Immed. C. S.	B. ↑ C. S. with later Rx	U. ↑ C. S. with later Rx	C. S. with later Rx	Total C. S.	No.	Immed. C. S.	B. ↑ C. S. with later Rx	U. ↑ C. S. with later Rx	C. S. with later Rx	Total C. S.	No.	Immed. C. S.	B. ↑ C. S. with later Rx	U. ↑ C. S. with later Rx	C. S. with later Rx	Total C. S.
Less than 6 months	6	4	..	..	..	4	13	2	2	..	5	9	7	1	..	..	3	4	19	6	2	..	5	13
Over 6 months	7	1	1	2	1	5	12	2	1	1	2	6	18	2	1	1	1	5	19	3	2	3	3	11
Total	13	5	1	2	1	9	25	4	3	1	7	15	25	3	1	1	4	9	38	9	4	3	8	24

In Patients Hospitalized Less or More Than 12 Months

	Histamine alone						Post-Histamine-ECT						ECT Control						Comb. HT plus Post-Histamine-ECT					
	No.	Immed. C. S.	B. ↑ C. S. with later Rx	U. ↑ C. S. with later Rx	C. S. with later Rx	Total C. S.	No.	Immed. C. S.	B. ↑ C. S. with later Rx	U. ↑ C. S. with later Rx	C. S. with later Rx	Total C. S.	No.	Immed. C. S.	B. ↑ C. S. with later Rx	U. ↑ C. S. with later Rx	C. S. with later Rx	Total C. S.	No.	Immed. C. S.	B. ↑ C. S. with later Rx	U. ↑ C. S. with later Rx	C. S. with later Rx	Total C. S.
Lest than 12 months	7	4	..	..	1	5	14	2	2	1	5	10	11	2	..	..	3	5	21	6	2	1	6	15
Over 12 months	6	1	1	2	..	4	11	2	1	..	2	5	14	1	1	1	1	4	17	3	2	2	2	9
Total	13	5	1	2	1	9	25	4	3	1	7	15	25	3	1	1	4	9	38	9	4	3	8	24

C.S.—Convalescent status B.—Benefited during test period U.—Unimproved during test period.

5. Three years after the test period, 27 of all 63 patients were found to be either on convalescent status or discharged. Analysis showed that seven were from the HT Group, 14 from the Post-Histamine-ECT Group, and six from the ECT Control Group.

Conclusions

On the basis of these data, and within the limitations of the series, this three-year follow-up confirms the findings of the original observation period, to the effect that:

1. Nonconvulsive biochemotherapy by itself achieves results in hospitalized (schizophrenic, manic-depressive and involutional) psychotics comparable to or better than ECT.

2. Nonconvulsive histamine biochemotherapy seems to have a potentiating effect on ECT given subsequently to histamine-refractory patients.

3. A regimen of nonconvulsive histamine biochemotherapy, followed by ECT for those not attaining convalescent status, may double the number of mental hospital patients now attaining convalescent status with ECT, if the results in this study are achieved with larger numbers of patients.

4. The beneficial effects of ECT cannot be attributed to histamine release alone if the data reported herein are borne out by subsequent large scale studies, though histamine release may be one factor in a complex phenomenon producing improvement.

In addition, one must conclude that:

5. Since ECT-refractory patients respond better to Post-Histamine-ECT than to histamine alone, or to a second course of histamine, patients previously refractory to ECT should receive histamine pre-treatment if ECT is to be prescribed.

6. Large scale studies with histamine alone and in combination with other modalities are desirable. Further study of this and other biochemotherapeutic regimens will contribute to, and in turn will itself be further advanced by research on, the etiology and pathogenesis of mental disease.

A large series of non-hospitalized psychotics and psychoneurotics treated with nonconvulsive histamine biochemotherapy; a series treated in conjunction with ECT and subcoma insulin; a study of effects on direct eosinophile counts; changes induced by histamine therapy as revealed in the Rorschach and other projec-

tive tests; and details as to technique with special considerations respecting peptic ulcer, hay fever and asthma—will be presented in subsequent papers. A working hypothesis presenting a phylogenetic concept and rationale in which nonconvulsive histamine biochemotherapy is related rationally to other indicated procedures will be offered in a forthcoming report.

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FACTORS INVOLVED IN THE GENESIS AND RESOLUTION OF NEUROTIC DETACHMENT

BY MONTAGUE ULLMAN, M. D.

Although the term "detachment" is in fairly common use, both descriptively and dynamically, its precise implications still elude a complete understanding. It is the object of this paper to attempt a close scrutiny of this particular defensive reaction in a patient who presents many of the typical problems encountered.

Many terms are used in conjunction with and in close relation to detachment. A detached person is said to rely heavily on the mechanism of withdrawal from reality. Depending on the person and the situation, he may be regarded as distant, aloof, untouched, preoccupied, removed, or remote. When there is greater affective coloring, his detachment may lurk under the guise of arrogance, cynicism, superiority, or snobbishness. Autism and dissociation are other terms that are related to the problem. As considered here, detachment is a way of reacting to one's environment, based on the illusion that it is both possible and necessary to disregard the real needs of people and to exist in a state of isolated independence. Fundamentally, it is an attitude toward the self, projected onto others, of extraordinary disregard and unconcernedness. This definition can be made more specific by a comparison of detachment with other neurotic devices. Any neurotic trend implies a "detaching process." Through the particular trend, the individual detaches himself, or attempts to detach himself, from what at the inception of the trend must have been a painful area of experience. In the case of neurotic trends other than detachment, however, there is an attempt to restore the equilibrium and compensate for the experiential handicaps by the use and misuse, manipulation and accentuation of real ways of influencing people. People retain their value, and it is still necessary to do things in relation to them. For the mechanism of detachment to come into being, the area of experiential injury must be so great that people are experienced as valueless, and for it to remain in existence, people must continue to be experienced as valueless. It is at great cost to the potential of the human being that this leap is made from the solid ground of human contact to the rarefied atmosphere of splendid (sometimes) but precarious (always) isolation. Once this leap is achieved, the road back entails all the difficulties of

any other neurotic trend, in addition to the specific problems involved in countering the conditioned shrinkage from meaningful contact which these patients automatically experience. Having placed themselves beyond the pale, people are willing to pay any price but one, that of psychosis. Unchecked, the end-result of detachment is psychosis, and it is the fear of "insanity" which, when real and intense enough, creates for the first time for these patients an alternative which heretofore did not exist, namely, that of getting well.

As just stated, any neurotic development includes a "detaching process" in the sense of an alteration in the appropriateness and directness of the reaction elicited by the situation. But in these individuals the detaching process is a means to an end, the end being to reach people. In neuroses where the detachment is a significant feature, the detaching process is not only the means, but—evolving out of its function, which is to delay or ward off appropriate contact—becomes the end in itself. The demands for contact are so great in the genesis of human development that almost all of the creative potential has to be invested in the establishment of a character structure which can carry the burden of endlessly maintaining the fiction of isolation. Detachment is in essence a controlled experiment in mental derangement, and so dangerous that the focus remains only upon the experiment. At some point, either the test tube breaks, or one manages to divert some attention to the experimenter. Unfortunately, by the time these situations are ferreted out, the experimenter has become little more than an automatic vehicle attempting to breathe a semblance of human aspect into the façade he has created.

Detachment, then, involves a profound alteration in the perceptive processes, resulting in the substitution for "reality as it is" of a "reality which can be ignored." It results from facing serious deprivation, and once initiated, occasions serious deprivation. Threats to the maintenance of the detachment become the only serious reality; and since the detachment is so invincible a weapon, immediate realities succumb before it and, in so doing, strengthen the defensive structure.

What happens characterologically to these people when the injury is severe enough to result in detachment is still not clear. Although applicable in a meaningful way, the concepts centering around narcissism and the failure of libidinal cathexis serve more

of a descriptive than an explanatory function, and seem too generalized for dealing with a condition which can be understood only when broken down, not only into complicated genetic factors, but also into operational techniques whereby it is maintained and propagated. Horney's evaluation of detachment, while stressing the resultant handicap and the compulsivity involved, does not sufficiently assess the unique qualities of this defensive maneuver, namely, the inexorable way in which the positive aspects of the personality are overshadowed, and the bearing this has on therapy —in short, the all-pervasive effect, the powerful, serious, and uncompromising break in the relatedness of the individual to his surroundings which is quantitatively, and eventually qualitatively, different than in the case of the other neurotic trends. The consideration given to the problem in this paper incorporates more of the serious implications of the Freudian views, namely, the earliness and severity of the causative trauma, with an outlook which is not so pessimistic as implied by Freud, nor so accessible and so manipulable as implied by Horney.

Essential to the understanding of defense by detachment, is the realization that neurotically detached patients have been subjected to environments where their treatment and recognition would have been far more appropriate had they been *objects* rather than *developing human beings.* The child encounters rigidity in the human environment to the point where his relatedness is contingent upon automatic conformity. The parental influence, appropriate for an imaginary "animate object," is totally inappropriate for the needs of the child. When the pressure for conformity is so great that the possibilities for genuine spontaneity are wholly lacking, there is an effort on the part of the child to adjust at the level of being an automaton or, in effect, a human object. Since this is impossible, he can only reach his goal by a process of simulation, based on his ability to disguise, ignore, or restrain all impulses that would be incongruous with this goal. Detachment, then, is the general term encompassing those characterologic changes designed to establish and maintain the profound degree of self-alienation necessary to make this type of adjustment.

Detached patients fall into two main, although not sharply defined, categories, depending upon the severity of the syndrome. In the first group the child is hit tangentially by the neurotic conflicts in the home. Although he may be exposed to them in the most dev-

astating fashion, his own existence is not significant to the operation of the neurotic drives of either or both parents. He is the innocent bystander who gets hurt. He is hurt, but not crushed completely. When the situation in the home approximates the conditions outlined here, the hurt results in detachment, but the injury, since it is partial, does not preclude some area of activity capable of yielding gratification. We see in these patients the severe handicap of detachment, side by side with the potentiality for growth and an almost indestructible optimism. The patient to be presented here typifies this group.

In the second group, the child not only experiences the impact of the neurotic conflicts in the home, but actually bears the brunt of the disorder. His existence forms the focal point of a destructive, neurotic fixation on the part of one or both parents. In the face of unrelenting pressure of this type, character development can take place only in defensive patterns. The total creative drive of the personality is spent in the service of maintaining the one mechanism *par excellence* capable of meeting this type of threat, namely, detachment. Any tampering with the detachment results in paranoid hostility and suspicion. Owing to the limited scope of this paper, this latter type of development—seen in psychotics and borderline psychotics—will not be illustrated by case material.

Case Presentation

Analysis in Progress 16 *Months*

The patient is a 30-year-old man who came to analysis in the midst of the following life situation:

He is an artist of a modern school whose work had achieved considerable recognition during the previous five years. About a year prior to coming to analysis, his first marriage had broken up, and the ensuing months had been characterized by feelings of despair, confusion, and frustration. Anxiety had become intense, and the patient had sought some relief through alcohol. Involved as he was, not only in painting and exhibiting, but also in writing, editing, and lecturing, he was ' rced, with great reluctance on his part, to participate in a round of social activities and parties which had come in the wake of his recent successes. He was beset with almost unbearable feelings of awkwardness and self-consciousness in these situations, as well as in his ordinary dealings with people. He be-

gan to feel more and more harassed and was finally incapacitated by a prolonged bout of chest infections. At the time of his first visit to the analyst, he had begun to recuperate a bit from a morass of physical and mental debility, though he still had considerable anxiety. He was concerned about his drinking and frightened lest the old feelings of confusion and panic return.

The patient's father had been an eminently successful business man. The patient recalls his childhood as characterized by a profound sense of isolation and the feeling that he simply did not belong. Both parents were concerned with possessions to the point where their protective attitudes seemed to operate more spontaneously in relation to possessions than in relation to the needs of their child. Orderliness, neatness, cleanliness, and conformity seemed to comprise exclusively all that was virtuous. The father's drive for power and prestige in the business world was matched by the mother's efforts to mold the home life in accordance with the pressures and demands of her husband's activities. She was a highly imaginative woman who in her ordinary dealings with people was flighty and ineffectual. The patient has often characterized her emotionality as primitive. The patient was an only child.

The patient was much alone during his formative years, with no close friends and very little group activity. At college he proved to be a brilliant student whose chief interest was philosophical theory. Following his graduation he studied both in this country and abroad, and finally accepted a teaching position in a leading eastern university. He held this position for a short time, and it was during this period that his interest turned to painting. In his middle twenties he left the university post and came to New York. He became acquainted with artists and soon began to paint on his own. He had had no previous experience in painting. When he did begin to paint, it was with an intensity and fervor he had never before experienced. Within a few years his work drew serious attention and at the time he came to analysis he was considered one of the leading "*avant garde*" artists in the country. He was continually in economic jeopardy despite a monthly check from his mother, which provided for his basic needs, and despite occasional sporadic financial returns from his paintings and writings.

His first marriage took place three years prior to the start of therapy. It seemed to come about with the same suddenness and intensity that had characterized his plunge into the world of art.

His wife was strikingly beautiful. She was rather distant and unresponsive, and it was only after a good deal of persuasion and initiative on the part of the patient that she agreed to marry him. She was untutored and unsophisticated, and much of the initiative that he showed in the marriage was devoted to cultivating her interest in art and literature. In many ways she seemed more naïve, impractical, and withdrawn than he. She shunned his social life and seemed actually unable to share in any social responsibilities. The relationship had a static and stagnant quality which eventually led to its termination by mutual consent. He experienced this break as both necessary and beneficial. He spoke of his wife with fondness, but also with a profound critical perception of her limitations in the marriage, as well as of his own, and of the impossibility of the relationship.

The early analytic situation was as follows: The patient had a very pleasant, agreeable approach. He was over-polite, however, almost to the point of obeisance. He would say "thank you" at the end of each analytic session. Anxiety about the therapy manifested itself by concern with the duration of treatment, efforts to manipulate the hours, and the repeatedly expressed hope that the treatment could be terminated in three to six months so that he could embark on a projected European trip. Analysis of these early features brought out his fear of involvement, his immediate reaction to a new situation as limiting and restricting, and his need to control, manipulate, and delimit any situation that was not of his own creation. He then began to focus more clearly on what heretofore had been but dimly sensed, namely, the feeling that there was something basically wrong with himself (something about himself which he characterized as inhuman) which filled him with a feeling of futility and at times desperation. He was referring to his detachment and the resultant inability to enjoy direct, relaxed contact with other people. This seemed in marked contrast to the optimism and inspiration he consistently felt in relation to his work. Despite his growing respect for the analytic process, his deferential, formal manner persisted, and there was little affective coloring to his productions except for the feeling of being trapped and helpless.

Several months after the start of the analysis, he began to broach the question of divorce. He struggled with considerable inertia evolving out of his reluctance to sever even for a brief time the

round of activities in which he was engaged in New York, to hazard a trip to Reno by himself. In addition to this, he was hampered by inflated notions of his responsibilities to his wife. He had little money of his own, and her support would devolve upon his mother. Despite these difficulties, it was felt that the move was not only right, but necessary at this time to clear the path for his own future development. He was actively encouraged, and finally did make the trip. He returned to New York two months later, having successfully carried through the arrangements with regard to the divorce. He had withstood the onslaught of his family, and he had in the interim become interested in a young woman, herself recently divorced.

During the next few weeks he spoke a great deal about this girl. Several things became apparent. She herself had just emerged from a very restricting and conventional marriage and had fallen deeply and genuinely in love with the patient. He found himself drawn to her for qualities which he had either never noticed or which were not there in the other women he had known. He was greatly taken by her warmth, her directness, and the undemanding nature of her attachment to him. There were moments when he would experience a positive sense of responsibility and commitment in relation to her, but these were, at least in the beginning, lost sight of in his fear of treading outside the sphere of art and art personalities. He feared the reaction of his friends to someone who had no special interest in art. For a time the relationship was stalemated and almost completely lost sight of.

The pressure to establish himself on more secure economic grounds—a theme which had recurred from time to time since the start of the analysis—was again considered, but this time was followed by definite action on his part. He had in the past received offers of academic posts, one of them as a professor of art, but he had rejected all of them, as he considered himself ill-suited for the quiet, and what he regarded as the restricting conventionality, of academic life. He did aspire, however, to have his own school of painting, although he had, up to this point, shied away from the idea. He greatly feared his own awkwardness and impracticality in effecting even the simplest and most ordinary business affairs. In addition to this, all the advice he received indicated that setting up his own school was the sort of venture in which only an older and more established painter could hope to succeed. On the other

hand, he did enjoy teaching and was successful at it, and he felt that he had original and significant ideas to present.

Again it was felt that the movement here was in the right direction, despite the fact that the outcome could not be certain. Analysis of the factors in his way, and encouragement and reassurance resulted in his taking the first steps. Within a few months, the school was a going concern and working out more smoothly than had been anticipated. Once this was accomplished, he seemed eager to resume and come to grips with the relationship with his girl. The two things about himself which disturbed him most—his compulsiveness about his work and his general aloofness and lack of concern for people and activities unrelated to the art world—now began to disturb him more than ever because of their specific destructive potential in relation to this girl. It was at this point that the fetishistic nature of his attachment to his own talent specifically, and to the world of art in general, was developed as a central analytic theme. His compulsive and all-engrossing concern with the art world was seen as a substitute means, although a necessary one, of relating himself to other people, a means born out of revulsion to, and intolerance of, the world as he had experienced it.

Although his talent was recognizable and real, he seemed to relate to it as if he himself were helpless, insignificant, and virtually nonexistent. He actually seemed to be trapped by the pleasure he experienced in the *act* of painting, a pleasure which seemed so all-consuming and powerful that it excluded any concern with the painting itself, that is, with the finished product. Whenever he discussed his work it was in terms of the *act* of painting; and only an occasional reference was made to a finished picture. He was impervious to the impact of his paintings on others (aloof and indifferent to his critics and his followers alike) and showed no genuine concern with an effort to harness some of the fruits of his creative energy in stabilizing his own life from the financial point of view (his economic situation having been precarious until he opened his own school). In short, he was relating in an unhuman and slavish way to his own creativity.

Once these matters were established, he began to struggle less against the recognition of his own need for the qualities which the girl had to offer. They were married within a year after his return from Reno. The marriage took place during the summer and

he was seen two months later. Despite the fact that he was still profoundly disturbed over his conflicts, the early period of his marriage had resulted in greater closeness with his wife, more real respect for her, and a greater eagerness to achieve some mastery over his own problems.

In the fall, he was again faced with the mounting pressures of preparing for exhibits, meeting editorial deadlines, arranging his school program, and participating in numerous other ventures in which he had become involved. In addition to this, there was the problem of setting up a home and studio. He became more and more aloof and distant toward his wife, lost interest in their sexual activity, which up to that point had been highly gratifying, and even at times felt reluctant to return home at the end of the day. His need to reject, withdraw, and remain uninvolved gave rise intermittantly to almost paralyzing feelings of hostility. He felt discouraged and futile in the analysis. The stage was thus set for a renewed effort on his part—although at a different level, by virtue both of his marriage and the self-confidence attendant upon his venture into teaching—to achieve his neurotic goal, namely, the pursuit of gratification in art at the expense of self-effacement and through the relinquishment of all responsibility in relation to other human beings. This attempt was again subtle and, like the initial attempt, became manifest by his efforts to control and delimit the analysis. He became preoccupied with the idea of moving to the West to free himself from the tensions and pressures which he experienced in New York, and thus be in a position to devote himself to painting in a total and more sustained way.

This material was analyzed as follows: It was pointed out to what extent his drive both toward marriage and toward analysis had incorporated within it the effort to become more human by osmosis, so to speak. Still laboring under the oppressive influence of his detachment, he had not relinquished the hope that his attachment to another human being in a passive, helpless, self-effacing sort of way could substitute for the task he faced, and conceived of as impossible—that of overthrowing his detachment and becoming a human being. Interpretations along these lines took the edge off the escapist impulses and brought out into the open his hope that what he had failed to do by himself, namely, to work out a way of life that would leave him unhampered and unfettered, he could now accomplish with his wife by severing all their ties

here and attempting a more simplified existence away from the pressures of civilization.

The fantasy of "one against the world" had evolved into "two against the world." It became apparent to what extent he was buffeted about by the importance to him of the act of painting, and to what extent this forced him to maneuver and overpower those to whom he felt closest. This understanding eased the situation in the analysis; but it was not until a short time later, that a very intuitive observation on his wife's part eased the tension at home. It occurred in the course of a conversation which took place at a time when their relationship had deteriorated to a critical level. She succeeded in pointing out to him that she did not take exception to his interest in and enjoyment of painting, but that she was puzzled by two things, first the fact that this interest seemed to be exclusively centered in the preparations and arrangements that went into the making of a picture, and not in the picture itself, and second, that it seemed to crowd out the possibilities of any other interests. It was the first time for the patient that what was most important to him was shared, accepted, and critically evaluated by a significant person. It also fanned the first genuine sparks of hope in his struggle to change himself.

The attitudes with which this patient will ultimately have to come to grips have to do with his concept of people either as dehumanized automatons, ruthlessly pursuing their predatory impulses and relating to others as if they were capable of being owned and manipulated (his perception of his father), or as basically parasitic and venting their emotionality in an aimless and uncontrollable way (his perception of his mother). His real impotence as a child in relation to this state of affairs gave rise to a negativism which, coupled with his sensitivity, resulted in a critical rejection of his own human environment and the values it represented. His existence seemed to hinge upon his ability to subjugate, not other people, as in the case of the powerful adults who surrounded him, but himself. The waste, the cruelty, and the alienation wrought upon himself and others by this attitude make a virtue of unawareness, blind him to the vulnerability of his detachment, and make an inexorable necessity of it. His talent and creativity, in forcing their way through these barriers, are cast out with little direction or goal, in hateful defiance of the oppression and melancholy that pervade his life. In rejecting the values about

him, he devotes himself to a search for absolute values. His sensitivity to line and color is a real attribute developed in his struggle to abstract beauty from the world of objects.

In summarizing the analytic process thus far, one sees that despite the fact that there has been very little analytic activity in the ordinary sense of the term, and despite the fact that the detachment is still operating, although not so effectively as it did in the beginning, the analysis has witnessed and supported some measure of real growth.

1. In the step toward marriage, the patient risked the first definite break with the kind of relatedness he had with the art world.

2. In the establishment of his school, he made the first wholehearted attempt to alter for the better the financially precarious, socially irresponsible, and generally unstabilized character of his earlier mode of existence.

3. The fact that both the analysis and his marriage have withstood his subtle but powerful efforts to manipulate and abort them has made him somewhat less fearful of his own destructive potential. It is this fear which must be mastered before he can experience his own neurosis as a reality rather than an abstraction, and can come to grips with his own terrible distorted attitudes toward people, attitudes which his detachment serves.

Although the detachment has not been fully resolved in this patient, it is no longer a bulwark against analytic progress, and some inferences may be drawn as to the factors involved in its resolution.

It is important to note that in the case of the more benign syndromes, the analysis itself actively challenges the defensive structure. In the case of the detached patient, the elements of struggle can be successfully hidden, at least in the beginning. In fact, the analysis is set up as a citadel against struggle. The analyst is not a significant figure to the patient. The latter is capable of experiencing people as significant only when they directly relate to his own area of creative function, and here their significance as people is overshadowed by their significance as manipulable and maneuverable objects. In the light of this, the steps in the process of resolution may be outlined as follows:

1. In a situation where no genuine human relationships have previously occurred, the analyst can only ally himself with a reality tool rather than a real ego. In the patient presented, this would refer to his talent and sensitivity.

2. Relatedness to people must be initiated by someone significant to the patient in relation to this reality tool. In the case of the patient presented, the neurotic component of his marriage (and by far the strongest component) was the hope of solving his human needs by blind, passive attachment to his wife. His wife thus became a significant figure to him. It is the pressure of this relationship, interpreted and handled within the therapeutic situation, which undermines his detachment and necessitates an active struggle against it. Not until the patient can actively identify himself with this struggle does the therapist become a truly significant figure for him.

Summary

1. Genetically, detachment develops as a defense against the enforced transformation of human potential into automatic, mechanical responsiveness.

2. Resolution depends on the full understanding of the fragmentary means of contact established by these patients and the ruthlessness with which it is protected.

3. A case is presented illustrating the analytic problems encountered in the therapy of a severely detached personality.

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THE EVALUATION OF TREATMENT*

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In evaluating the effects of the hospital treatment of patients suffering from mental illness, many factors must be taken into consideration. In the first place, there are several different types of mental hospitals, and one would expect corresponding differences in results. There are the private and voluntary mental hospitals, the psychiatric services of general hospitals or the psychopathic hospitals, the public state hospitals which admit directly, the public state hospitals which admit from psychopathic hospitals, and the veterans' hospitals. It is hoped that studies from these various types of hospitals can eventually help to establish ways of comparing results.[1] As the writer's experience is limited to voluntary hospitals, this paper will be concerned with the results of treatment in the New York Hospital—Westchester Division, White Plains, N. Y.

The New York Hospital—Westchester Division, with a bed capacity of 301 patients, has spacious grounds and is well equipped for program therapies, with two gymnasia, two occupational therapy buildings, and outdoor athletic fields of various kinds. The staff is made up of 18 resident physicians, and there are approximately twice as many employees as patients. Under such conditions, the therapeutic approach is naturally intensive. In addition, preference is given to patients suffering from acute psychiatric disorders. The majority of the patients admitted are either young or middle-aged. The average age of all patients admitted is 42. Patients who do not respond to treatment over a reasonable length of time may be transferred, hence an atmosphere of hopefulness is maintained. With the ability to select patients, together with the early institution of intensive treatment, the results might be expected to be good.

Each year the hospital reports the number of admissions, including first admissions and readmissions. In the reporting of discharges, the condition of the patient at the time of discharge is recorded. This includes the number who have been on visit for a year after leaving the hospital, those who are discharged directly from the hospital, and those who are transferred to other hospitals,

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or who have died. In addition, at the weekly staff conferences where patients are presented for diagnostic consideration and therapeutic suggestions, the case histories of patients who were considered a year previously, are reviewed to determine their progress.

During the past 20 years there has been an increased number of admissions and discharges, because of improved methods of treatment, notably the addition of the various forms of shock treatment, which have enabled more patients to achieve a responsive state to intensive psychotherapy earlier, and the various program therapies. The hospital's statistical studies show that the number of patients under treatment during the year, as well as the number of discharges, has greatly increased. Naturally, under these circumstances, the duration of hospital residence for individual patients has been markedly shortened.

The following tabulation shows something of the activity of the hospital in 1950 as compared with 20 years ago:

	1930	1950
Number of patients admitted	242	329
Number of patients discharged	259	345
Number of patients under treatment	545	722
Average daily number of patients in hospital	251	272
Number of patients discharged who had benefited by treatment, in hospital less than six months	92	143
Number of patients discharged who had benefited by treatment, in hospital less than a year	144	244
Total number of patients discharged who had benefited by treatment	187	276

In addition to studying the condition of all patients at the time of discharge, the staff has made studies of results of hospital treatment of patients according to diagnostic groupings and in some instances according to occupations and professions. One of the outstanding studies made by the staff was "Results of Non-Specific Treatment of Dementia Præcox," by Cheney and Drewry.[2] Five hundred patients, 300 women and 200 men, admitted from 1926 to 1935 were studied. At the time of leaving the hospital, 37 per cent had been benefited by treatment and 7 per cent had recovered. The follow-up period after discharge was from two to 12 years and the results showed that 30 per cent had benefited by treatment and 12 per cent had recovered at the time of the check-

up. Approximately 60 per cent were unimproved, and 43 per cent were continuing under care in mental hospitals. The study showed that at the time of discharge 10 per cent of the patients with catatonic dementia praecox had recovered and at the time of the follow-up study, 20 per cent of the catatonic patients had recovered, showing that this group had a better chance to improve after leaving the hospital than the other types.

During the past 20 years, an increasing number of psychoneurotic patients have been admitted to the hospital. Some of these patients had been under intensive psychotherapy for a number of years before coming to treatment. They had not responded and were apparently greatly benefited by the more supportive and continued type of treatment afforded in a mental hospital. In 1941 and 1942, studies were made by Hamilton, Varney, and Wall[3, 4] on the results of hospital treatment of patients with psychoneurotic disorders. Of 100 psychoneurotic men patients admitted between 1927 and 1937, follow-up studies revealed that from five to 15 years after discharge, 32 were recovered. The study showed the value of a full and varied program of activities together with psychotherapy, to this group of patients.

In 1948, Hamilton and Ward[5] studied the results of the hospital treatment of involutional psychoses. This study was concerned with 100 women patients suffering from involutional psychoses admitted consecutively between 1930 and 1940. The results of treatment in this group which did not have electric shock therapy were compared with the results obtained in a group of 69 women patients admitted between 1942 and 1946 who, in addition to other forms of treatment, had received electric shock therapy. In the group of 100 patients who did not have electric shock therapy, after a follow-up period of from seven to 16 years, 32 were recovered; and in the group of 69 who had received electric shock therapy after a follow-up period of from one to five years, 33 were recovered. Of great importance, was the fact that for the first group the average length of hospitalization was two years, in contrast to only an eight-month period of hospitalization for the group treated by electric shock therapy. This study bore out the experience of other clinics that electric shock treatment is most helpful in shortening the period of treatment of patients with involutional mental illnesses. Oftentimes patients with involutional reactions

received several series of electric shock therapy during their hospital treatment. This therapy allays the disturbing symptoms of anxiety and agitation previously met with and greatly decreases the suicidal drives which are so prominent in this group of patients.

In 1940, Clow[6] reviewed the results of treatment of 100 patients suffering from psychoses with cerebral arteriosclerosis. This investigation showed that these patients had been admitted over a period of 22 years and that 11 of them were sufficiently recovered to resume work effectively, 12 were much improved, and half of them had been able to return to their homes. The study demonstrated that mental disturbances in arteriosclerotic persons are not necessarily so progressive and incurable as may be believed.

Allen and the writer reviewed the results of hospital treatment of alcoholism in 1943.[7] The study was concerned with 100 men who were under treatment during the period 1934 to 1940. The follow-up studies of these 100 men, three to eight years after discharge, revealed that 23 were recovered and 19 were managing better, making a total of 43 who had been definitely benefited by treatment. Thirty-three in an unimproved condition were still drinking; 15 patients had died; and for nine, information regarding their course after leaving the hospital could not be obtained. Subsequent studies of a comparable nature by other members of the staff have shown similar results.

It is obvious that these remarks are concerned with a limited experience and represent a very small proportion of the number of psychiatric patients under treatment, but they should give a general idea of what we are attempting to accomplish in our voluntary hospitals where circumstances make possible selection of patients, intensive treatment, and transfer of unresponsive patients.

Statistical studies are important, but they cannot measure some of the intangible qualities of psychiatric work and experience. Many patients who continue with a burden of illness after discharge are able to make contributions to society and are frequently a great comfort to those with whom they live. A period of treatment for a patient who is not responsive often affords time for the whole family to get a different perspective on the patient's problem. Often a mental illness is an experience through which the person moves and comes to grips with life problems in such a

way that he is able to function more effectively. The far-reaching effects of an illness in a family stimulate greater interest in psychiatry, which may lead not only to improved standards of treatment, but also to greater community participation in the promotion of mental hygiene and the prevention of mental illness.

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A TREATMENT PLAN COMBINING GROUP AND INDIVIDUAL PSYCHOTHERAPEUTIC PROCEDURES IN A STATE MENTAL HOSPITAL*

BY JACK GREEN, M. D.

The problem of rehabilitating state mental hospital patients by means of psychotherapy is often made exceedingly difficult by the large number of patients, the relatively small number of physicians, and the great severity of the illnesses encountered. The psychiatrist is often at a loss as to what policy he should follow. Should he concentrate his efforts on a few individuals whom he has singled out for intensive therapy, or should he try to make contact with as many patients as possible? One of the most difficult things to estimate is a patient's ability to benefit from psychotherapy. Whom should the physician choose among the scores who need his help? Should he continue treating for months and years one individual who is progressing very slowly when there are other candidates waiting who may recover more quickly, given this same attention? What is the maximum number of patients which can be treated effectively by one therapist? These questions which only remotely affect the psychiatrist in private practice, constitute an important problem which constantly faces the institutional physician. They challenge him to become more skillful in using the small amount of time he can spend with each patient. They tempt him to modify the available therapeutic techniques to fit his needs more closely. A treatment plan which has been used with some success in attempting to deal with the problems outlined here, will be described.

Treatment Plan

The plan to be presented is designed so that one physician can carry out the treatment of a group of 40 patients with a combination of group and individual psychotherapy. The therapist devotes two hours twice a week to the group therapy, and directs the rest of his time toward 20-minute private interviews with as many patients as possible. The group is constantly changing, for as certain members get better and leave, new candidates are invited to come in and take their place. Some have to remain in the group

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for as long as a year or more, while others are able to leave after several months. Almost any patient who is not markedly disturbed can be accepted for treatment. Whether an individual has only recently become ill, or has had many years of treatment with the various physical therapies and psychotherapy, does not matter, except insofar as the more recent the illness, the better the prognosis.

When a patient first enters the treatment group, he is immediately invited to attend the two group therapy conferences every week. During these sessions, which will be described at some length, the physician gets the opportunity to become acquainted with the new patient. Whether the latter becomes an active member of the group or remains a passive observer does not really matter. Within a few weeks, the therapist learns a great deal about the new patient without actually taking time to interview him privately. Some individuals, of course, reveal less of themselves than do others.

Within a short time, the new member of the group becomes aware that some of his fellow-patients are receiving a lot more attention than he is from the physician—in the form of the private 20-minute interviews. Some patients are seen once a week in this way, some twice a week, and occasionally an individual has three interviews a week. These interviews are in addition to the semiweekly group therapy conferences which everyone attends. The physician is also available to his patients at some time or other during the day for a few minutes consultation regarding pressing problems. All private interviews of longer duration, however, are regular 20-minute periods which are scheduled by the therapist in advance as part of the treatment plan for the individual patient. The patient's appointments do not change from week to week or depend on whether he feels he has any problems to bring up at the interview time. The patient can expect to continue with his schedule until he is definitely better or until there is mutual agreement that he can get along with less time.

When the new member of the group realizes that the physician spends considerable time with certain patients in an effort to help them, he begins to hope that one day he too will have private interviews. During these interviews he will have the psychiatrist all to himself and will not have to share him with others as he does during the group therapy sessions. This goal becomes something

that most patients, including many who are very sick, begin striving for to a greater or lesser degree, within a matter of a few weeks. Some will ask outright, "When can I be started on private interviews?" Others will not be so verbal, but will behave as much as possible in a manner designed to make the physician feel that he has before him a candidate who would greatly benefit from private interviews. There are also those unfortunate ones who can betray their longings only in their expressions of frustration, abandoning themselves to blind rages, breaking things, and executing other negativistic acts aimed at denying the wish to possess the therapist.

The psychiatrist must not promise anything to the patient. The latter's desire to spend more time with the physician, and the subconscious wishes which accompany this desire, originate within the patient. Eventually it will be the seeing and the acceptance of these desires by the patient which will lead toward his becoming more capable of effective and satisfying behavior. If the therapist does anything to foster even more unrealistic hopes in the patient than are already present, the latter will use this action to avoid seeing himself and will eventually, with some justification, blame the therapist for the resulting frustration. Nevertheless, the physician must still appear friendly, sympathetic and tolerant, otherwise the patient will lose all hope of any of his wishes ever being satisfied. For those patients who greatly fear their own hostile impulses, it is also necessary that the psychiatrist appear very competent and "strong." Such a competent and strong physician is reassuring to them, because, presumably, he will not permit them to express their dangerous, aggressive promptings freely, and this reassurance allows them to build a closer relationship with him than would otherwise be possible.

Group Psychotherapy

The group therapy sessions at Howard (R. I.) State Hospital are conducted along the following lines. In a two-hour period much can be accomplished, even though the group is so large. The therapist does not remain passive as a rule, although there are many exceptions to this. His role is a difficult one, and no set of instructions can guide him. There are moments when he can be most effective by remaining as quiet and as permissive as possible, and there are other moments when he must push the group into

facing and accepting realities. He must bear, without retaliation, the hostility directed toward him, and yet when necessary, he must not be afraid to confront the group with material which might prove exceedingly painful. To do all this, he must have sufficient freedom from his own anxieties to examine honestly his deepest attitudes toward each patient and the group as a whole. For the first half-hour of each session, he allows the group to elaborate their own subjects. He listens carefully, trying to understand what each patient means to say and why he is saying it. After he has obtained some idea of the feelings, motivations, and resistances he has to contend with, and after he senses the mood of the group, he begins to encourage, stimulate, and ask questions. He helps develop subjects. Little by little he becomes more active in the discussion. He offers praise, criticism and inspiration. At times he allows himself to be led, at other times he leads. As he goes along, he tries to evaluate the group's reaction to what he is saying. Do they agree, are they angry, have they become anxious? Are they annoyed, irritated, or resentful? Why? Are they ready to accept what he is going to say? Toward the end of the two hours, if the discussion has progressed according to his plans, the therapist should be explaining and interpreting to a group that is anxious to listen to him.

Interpretations should be given only when the time is ripe and in a way that is acceptable to as many members of the group as possible. If the two hours are drawing to a close and the group is not ready to accept any interpretations, it is best to break off with questions left unanswered. It is important, that, if at all possible, interpretations should be given only when there are many incidents and examples at hand to help prove their correctness. During the whole two-hour period, the therapist rather bides his time, gathering and elaborating various incidents and examples brought up by the patients in order to demonstrate eventually the validity of his claims and comments. It is striking how a general statement will often mean nothing to a patient from an emotional point of view until it is associated with a specific example pertaining to that patient. If the patient has described the example himself in the presence of the group earlier in the period, the effectiveness of the interpretation is many times multiplied. The patient blushes, the group laughs. It is not necessary for anyone to confirm verbally the truth of what the therapist has said. Each patient usu-

ally sees the shortcomings of his neighbor much more readily than his own. When he hears an interpretation given which he easily recognizes as applying to his neighbor, and when he observes the latter's resistance to accepting it, even in the face of overwhelming proof, he becomes aware of a great deal which he has been sorely tempted to deny.

What are the therapist's more specific aims in the group therapy procedure? Although these vary with changing circumstances, the psychiatrist tries primarily to provide his patients with stronger and more pressing motives for seeking his help and getting better. Patients who have been attempting to satisfy their desires in fantasy are reminded constantly that ultimate true satisfaction must lie in the reality around them; that with the physician's help it is possible to achieve this satisfaction. When the members of the group are brought up against reality, they become anxious, tense and uncomfortable. They are tempted to withdraw, to run away; but they are also tempted to run to the therapist. If the latter is right there, offering his sympathy, friendship and help, those patients who are anxious and troubled may turn to him in their moment of need. This turning toward the therapist often marks the first step on the road to improvement and, perhaps, recovery. It should be pointed out, of course, that the physician must avoid provoking such overwhelming anxiety that patients are forced to retreat more deeply into their illnesses. The writer's experience has been that the more an individual has become integrated within the group, the greater has become his ability to withstand narcissistic traumata. His tendency to regress has become less marked and he has become more able to react to the therapist with anger, hostility and criticism.

Patients who need additional support during periods of emotional crisis, can at times be greatly helped by encouragement and praise given during the group therapy sessions themselves. But in addition to this, the physician must support such individuals during the private interviews he has with them. It is striking how effective he can sometimes be, even though these interviews are relatively short and far between.

The secondary aims of the therapist conducting the group therapy sessions, include focusing the attention of the patients upon the ultimate goal of getting well and leaving the hospital. There is a great tendency in state mental hospitals for patients to lose

sight of the fact that their destinies need not lie within the hospital itself; that satisfying adjustments can be made outside the hospital; that their energies can be far better directed toward improving themselves rather than toward trying to make their hospital existences more comfortable. The effectiveness of direct, verbal inspiration which the therapist can sometimes give the group, should not be minimized. He can also inspire the members indirectly by his own behavior, which he should always try to keep as sincere and as sympathetic as possible.

The existence of the group itself, offers many advantages to both the patient and the therapist. Each patient, even if he hasn't been granted private interviews, gets a chance to see his physician, speak to him, and hear him speak at least twice a week. This does away to a large extent with the feeling of being neglected which many patients develop in a state hospital. The psychiatrist would have to devote a minimum of four hours a week anyway, in trying to keep in touch with the conditions of his 40 patients even in the most superficial way. Two or more patients often have the same questions to ask and the same complaints to voice. Once these are brought up in the group therapy sessions, they can be discussed for all to hear. The group helps the new patient orient himself more quickly to his surroundings. The numerous incidents occurring between patients on the ward, their feelings and attitudes toward each other, and their day-to-day relationships with the hospital, often assume great meaning during the group therapy sessions. Patients are inspired by the improvement of fellow-members of the group. They can see how certain individuals in their midst, who are anxious, fearful, depressed, or perhaps suspicious and distrustful, gradually change in their attitudes and expressions over a period of months, and eventually become adequate enough to leave the hospital and attempt adjustment in the community outside. The physician, in meeting his 40 patients twice a week, is able to decide more readily than he might otherwise, who among the group is in the greatest need of individual psychotherapy and who would be most likely to benefit from it significantly. The group therapy sessions also provide the new patients with the opportunity of getting to know their physician at first hand and not through ward rumor and fable or through a few infrequent moments of hasty conversation. In a state mental hospital this can be very impor-

tant, for the therapist often has to serve as the first representative of reality that the psychotic patient can emotionally relate himself to with any degree of adequacy.

Individual Psychotherapy

While conducting the group therapy conferences, the therapist tries to evaluate the individual members of the group with respect to their ability to benefit from private interviews. This evaluation is important, for, as has been mentioned, once the interviews are started, they should not be discontinued except by mutual agreement. Unless there is a possibility of changing therapists, lack of improvement is not cause for termination of treatment. Indeed, such lack probably indicates that the patient requires even more attention, and perhaps more enlightened therapeutic management from the psychiatrist. However, some patients require such tremendous amounts of support and time to achieve even the most minimal improvement, that it is not practicable to treat them at the expense of other individuals who can progress more readily. Trial periods of treatment are best avoided. The temptation to use them may be great, for, in this way, the physician can shield himself from therapeutic failures. Unfortunately, he will be shielding himself from therapeutic successes as well, for the patient in his repeated testing of the therapist-patient relationship often does a great deal to force the physician to give up. If the physician does give up, the patient unfortunately interprets this as a rejection or an abandonment by the psychiatrist. In such an occurrence, he finds further justification for his own way of life, for his suspicion of people around him and his flight from reality.

In the private 20-minute interviews, the patient is told that he can use the time in any way he wishes. The physician indicates that he will try to help him with whatever problems are brought up. The therapist seeks to have the patient express himself as freely as possible. He also seeks to understand the forces which inhibit such expression. Within the framework of the interviews, the patient is allowed to build a relationship with the physician which will mirror his wishes, attitudes and strivings.

The therapist's aims are best served by careful, persistent listening. Again and again he must ask himself, "What is the patient trying to say? How is he relating himself to things, events and persons around him? How did he relate himself five, 10, or 20

years ago?" In every word, expression, and gesture of the patient, there is infinite meaning, if it could but be understood. The individual uses certain modes of adjustment to deal with his internal and external pressures. What are these modes? Can they be improved? Can new ones be learned?

The physician wishes to know what conflicting forces are battling within the patient's personality. If he can uncover these forces and evaluate their strengths and weaknesses, he can organize his therapeutic efforts, whether they be large or small, to strengthen and support consistently that part of the personality which must eventually predominate, if the patient is ever to become a harmoniously functioning individual. How much of the battle raging within the patient should be revealed to him, when it should be revealed, when he should be supported, and when he should be left to work things through on his own, are complex considerations. They depend on the skill and experience of the therapist, the difficulties of the patient, the amount of time the therapist can invest in the treatment, and other factors which vary from case to case.

General Comments

Although the 20-minute interviews are mainly used to help the patient make the adjustments necessary for leaving the hospital, they are also used to evaluate the individual's potentialities and future needs with respect to therapeutic management. The way is left open for a more intensive and lengthy analytic investigation and for the rebuilding of the patient's personality when and if such a procedure becomes feasible. The majority of patients are continued on short interviews after they leave the hospital. They are also invited to attend the group therapy conferences if they wish.

Our experience has been that about one-third of the patients who have been on private interviews arrange, upon leaving the hospital, to continue with one short interview a week. Another third decide to discontinue interviews, indicating that they either feel that no more are necessary or that they intend to see a psychiatrist in the community. The remaining group is a mixed one, made up of individuals who continue with as many as two or three interviews a week or as few as one or two a month. If a patient indicates that he would like to call the physician by telephone occasionally, he is encouraged to do so.

Although the plan outlined for combining group and individual psychotherapy offers certain advantages in the treatment of relatively large groups of patients, it should be noted that the effectiveness of the therapy depends on the skill and understanding of the therapist, and not on the treatment plan.

Summary

The rehabilitation of state mental hospital patients by means of psychotherapy poses special problems, because of the large number of patients, the relatively small number of physicians, and the great severity of the illnesses involved. A treatment plan which attempts to deal with these problems by using a combination of group and individual psychotherapeutic procedures has been described. The group therapy procedures in this plan are mainly used to provide the patients with stronger and more pressing motives for seeking the therapist's help and getting better. This is done, among other ways, by provoking anxiety, offering praise and support, and by direct verbal inspiration. The individual psychotherapy procedures are mainly used to give the patient a chance to express himself, to allow him to build a strong relationship with the therapist, and to uncover the factors responsible for his illness. The effectiveness of the therapy depends on the skill and understanding of the therapist and not on the treatment plan.

State Hospital for Mental Disease
Howard, R. I.

HISTAMINE THERAPY IN PSYCHIATRIC DISORDERS*

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Introduction

This is a report of the use of histamine therapy in patients with various psychiatric disorders. The writers' interest was aroused by the reports of Sackler, Sackler, Sackler and Van Ophuijsen at Creedmoor (N. Y.) State Hospital.[1-3] These investigators have reported that this drug is safe and effective and "a therapy of choice" in the treatment of schizophrenia and other psychiatric disorders. They reported good results with the use of histamine alone and also with its use in combination with electric shock and insulin therapy. Not enough of the present writers' patients received these other therapies after having received histamine for the writers to report conclusions; consequently this report is limited to treatment with histamine alone. Also it is easier to evaluate the effect of a drug when it is used alone, rather than when it is used in combination with other therapies.

All patients in the present study had been hospitalized less than a year when histamine treatment was instituted. The technique of treatment used by the investigators mentioned was personally observed by one of the present writers (A. S. E.) and was followed as exactly as possible in the cases reported in this paper.

Method of Study

Clinical Material

1. The writers' investigation of histamine treatments was initiated in December 1950 and terminated in March 1951.

2. Twenty-three patients at the New York State Psychiatric Institute were chosen. Twelve were female, 11 male. Chronic patients with long hospitalizations were not included.

3. The diagnoses of these patients were: schizophrenia, 16; manic-depression, depressed, 2; involutional psychosis, paranoid, 1; psychoneurosis, conversion hysteria, 2; and organic psychosis 2. The details of the specific types are included in the accompanying table. The diagnoses were made by the regular staff members according to routine practices.

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Table 1. Patients Treated with Histamine

Diagnosis	No. patients	No. patients with previous somatotherapy	Average duration hospitalization prior to Rx	Range hospitalization prior to Rx	Average age	Age range
Schizophrenia	(16)	(7)	(5 mos.)	(1 to 12 mos.)	(20)	(17 to 36)
Paranoid	4	1	4 mos.	1 to 8 mos.	21	19 to 23
Pseudoneurotic	5	2	6 mos.	2 to 12 mos.	30	22 to 36
Catatonic	1	1	5 mos.	5 mos.	17	17
Simple	1	0	4 mos.	4 mos.	25	25
Hebephrenic	1	0	2 mos.	2 mos.	27	27
Depression	1	1	10 mos.	10 mos.	23	23
Mixed	1	1	5 mos.	5 mos.	17	17
Undetermined	2	1	5 mos.	1 to 9 mos.	17	17
Manic-depression						
Depressed type	2	1	1 mo.	1 mo.	40	35 to 46
Involutional psychosis						
Paranoid type	1	0	1 week	1 week	49	49
Psychoneurosis						
Conversion hysteria	2	0	2½ mos.	2 to 3 mos.	40	40 to 41
Organic psychosis	(2)	(1)	(4 mos.)	(3 to 6 mos.)	(48)	(46 to 50)
Alzheimer's disease	1	0	3 mos.	3 mos.	46	46
Sensory aphasia	1	1	6 mos.	6 mos.	50	50
Total	23	9	4 mos.	1 wk. to 12 mos.	28	17 to 50

4. The age distribution varied from 17 to 50. The average was 28 years.

5. Only one of the patients had had a previous mental hospital admission; this one had been in another mental hospital for a period of only four days.

6. The lengths of hospital stay prior to histamine therapy ranged from five days to 12 months. The average length of hospitalization before the institution of histamine therapy was four months.

7. Seven of the 23 patients had received either electric shock therapy, insulin coma therapy or both, and two others had received ambulatory insulin therapy prior to the histamine. All of the patients received psychotherapy prior to, during, and following, histamine.

Procedures

PREPARATIONS

An effort was made to administer the treatment in the exact manner used at the present time by the original investigators.

All patients had complete physical and mental examinations and routine laboratory and psychological tests. The patients received the histamine in groups of about 10. They continued on their regular wards and with the usual hospital activities, and continued to see their own physicians for psychotherapy. No other medication than the histamine was given during the treatment period except occasional catharties and sedatives. Adrenal cortical extract, epinephrine and oxygen were present in the treatment room for emergencies.

THE THERAPY

The histamine was always administered subcutaneously. The Creedmoor group reported in their paper[1] that the medication was given by the intravenous, intramuscular, or hypodermoclysis method. However, more recently the subcutaneous route was being used by them, since it is simpler and apparently equally effective. The patients' pulse and blood pressure were checked daily, before treatment. The patients were all started on 0.25 mg. of histamine base (initial injection) and given two injections daily. After the first injection, the patients' pulses and blood pressures were recorded at five-minute intervals. The initial fall in blood

pressure usually occurred within 10 to 15 minutes after the injection, and the pressure and pulse were back to normal within 30 to 45 minutes. At that time, the second subcutaneous injection of histamine was given. If the blood pressure had fallen to shock levels, or if symptoms such as chest pain and marked dyspnea occurred, the initial dose was repeated or, on rare occasions, the second dose was slightly decreased. If the blood pressure had not fallen to shock levels, the dose was increased by 0.25 mg. of histamine base for the second injection. The next day, the patient received initially the same dose as he had received for his second dose the previous day. The maximum single dosage of histamine, administered to any one patient was 5.5 mg. of histamine base.

During the treatment, the patient was asked what he felt and his observations were noted by the nurse. Also spontaneous productions were noted. A day's treatment took about one and a half hours. The patients complained of throbbing headache, flushing, itching, metallic taste in the mouth, difficulty in breathing and dizziness. However, there were no severe reactions during the treatment. On one occasion, oxygen was given a patient when she complained of difficulty in breathing. Oxygen was given to another for a marked prolonged cyanosis.

The patients received 30 treatments with three exceptions. One refused to return to the hospital after 12 treatments. One detriorated very rapidly in behavior after 20 treatments and was put on insulin coma therapy; and treatment of one patient with an organic condition, characterized mainly by sensory aphasia, was stopped after 23 treatments for administrative reasons. The treatments were given six days a week and were consecutive except in the case of a patient who made a suicidal attempt and missed treatments for a two-week period.

Results of Histamine Therapy

In the first week of therapy, many of these patients subjectively experienced a feeling of greater relaxation, indicated that they were less tense and that they felt as if they were "up in the clouds," and could think more clearly. One female patient expressed the feeling, during the first treatment only, that it was as if she had had several cocktails. Whether this generally favorable effect derived from the physiological impact of the histamine or from the suggestive element associated with some form of actual physical

treatment is open to question. As the cases were carefully reviewed, it was found that most of the patients who expressed some subjective improvement during the first week of histamine treatment, had also experienced similar initial feelings of well-being when previously receiving other forms of drug therapy, such as thyroid, intravenous sodium amytal or a mild sedative. As with these other therapies, the subjective improvement was not sustained.

As the histamine treatment continued beyond the first week, almost all those patients showing initial favorable responses soon reverted to their previous states of illness, and a few complained that they were feeling worse. One male patient with conversion hysteria, manifesting hemiparesis and hypesthesia, showed a remarkable recovery after the first few injections. He did not like this treatment very well and was impatiently waiting for the therapy to end. He was a highly suggestible individual and his original symptoms began after an alleged head injury, the matter being in litigation at the time. There was some question originally as to whether the patient was not malingering. This man's recovery was in the nature of a "miracle cure." One female patient, also suffering from a milder form of conversion hysteria and constantly requesting some form of somatic therapy, showed a moderate amount of improvement. These were the only two patients who manifested any favorable response after the histamine ended.

Of the entire series of 23 patients, seven complained of being worse after therapy ended. Five were male patients and two female. This aggravation of symptoms was corroborated by objective observation. Five of these patients were diagnosed as schizophrenic, the majority of them showing some depressive symptomatology, one had Alzheimer's disease and one an agitated depression. Again it was difficult to determine whether the histamine was directly producing worsening of their conditions or whether the disease processes themselves were progressing in spite of the therapy administered. One male schizophrenic patient became so actively suicidal after the sixth histamine treatment, that therapy was discontinued for two weeks, and then resumed without in any way favorably influencing the disease. Another schizophrenic patient became so assaultive and disturbed in his behavior, with marked accentuation of his symptoms, that it was necessary to discontinue histamine therapy after the twentieth

treatment and to place him immediately on insulin coma treatment. Here it was observed that, after the seventh insulin coma, his acute symptoms subsided and he reverted to his pre-histamine condition.

Case Reports

H. A., a 41-year-old man with a diagnosis of psychoneurosis, conversion hysteria, was admitted to the Psychiatric Institute on November 2, 1950. Ten days before admission he had suffered a mild head injury, associated with persistent amnesia. Neurological examination on admission revealed a hysterical right hypesthesia and hemiparesis. The patient was dependent, taciturn, depressed, anxious, and at times antagonistic. He improved slightly with previously administered psychotherapy. With histamine he relaxed more completely and his symptoms disappeared. The patient commented that he did not like the discomfort of the histamine treatment.

G. L., a 49-year-old diabetic woman with a diagnosis of involutional psychosis, paranoid type, was admitted to the Psychiatric Institute on January 22, 1951. The patient became markedly depressed, agitated and suspicious, and expressed self-condemnatory ideas following the death of her husband four months before her hospital admission. She had made three suicidal attempts during the fortnight prior to admission. With histamine, the agitation and depth of the depression diminished to a slight degree. However, she continued to be depressed, retarded, and paranoid. She subsequently responded very well to electric shock treatments.

J. M., a 17-year-old girl with a diagnosis of schizophrenia, mixed type, was admitted to the Psychiatric Institute on November 29, 1950 with severe headaches and irritability. She was seclusive, negativistic, expressed feelings of unreality, and had visual and auditory hallucinations, though rarely. Before the use of histamine, she became more relaxed and talked more freely with the help of psychotherapy. During the period of administration of histamine her irritability increased and she complained of a greater sensitivity to noise. "The histamine made me more nervous." Her hallucinations and feelings of unreality were more marked.

C. K., a 42-year-old woman with a diagnosis of psychoneurosis, conversion hysteria, was admitted to the Institute on August 10, 1950. She was a dependent, inadequate, insecure woman who had

first become depressed two years earlier following the death of her fiance. She complained of anxiety attacks with fear of crowds and fear of riding in buses or subways. She had multiple vague somatic symptoms characterized by headaches, dizziness, excessive fatiguability, and an unsteady gait. With histamine therapy she became less depressed and more interested in socializing. The somatic complaints diminished to such a degree that for the first time in years she stated she felt fine. About three weeks after the histamine therapy was terminated, discussions with her psychotherapist began to center about the possibility of her leaving the hospital and obtaining a job. All symptoms returned to an exaggerated degree.

A. H., a 46-year-old man with a diagnosis of manic-depressive psychosis, depressed type, was admitted to the Institute on December 21, 1950. Eighteen months earlier he had received 20 electric shock treatments for depression. He improved with this therapy but his symptoms recurred in a milder form five weeks later and continued to the time of his current admission despite psychotherapy. There was an additional history of brief periods of depression 30 and 14 years before, respectively. At the time of the current admission, the patient was depressed, irritable, had obsessive suicidal thoughts and vague somatic complaints. There was no change during or after histamine therapy.

Comment

The results of histamine therapy in this group of 23 patients with psychiatric disorders were exceedingly disappointing. These results are a definite contradiction of the reported improvement in 26 per cent of their cases by Sackler, Sackler, Sackler, and Van Ophuijsen. Although the total number of patients included in the writers' study was statistically limited, the group did include a sampling of the major types of psychiatric disorders.

Of the 23 patients, only two manifested favorable responses. These two patients suffered from conversion hysteria, a condition especially vulnerable to any form of suggestion. In addition to the suggestion caused by the physiologic effect of the histamine injection, the constant presence of the physician taking pulse rate and blood pressure readings every five minutes for the period of each treatment was an important psychotherapeutic factor.

Seven patients became worse during the course of histamine therapy. This aggravation of clinical findings was not attributed to the histamine effects *per se*.

The remaining 14 patients were entirely unaffected by the histamine therapy. Of this group, 11 patients were schizophrenic, two were manic-depressive, depressed type, and one case was an organic psychosis. In evaluating the effect of therapy in these cases, the temporary favorable initial response seen in many of the patients was not recorded as a beneficial response.

Summary and Conclusions

1. The effects of histamine therapy were clinically evaluated in 23 psychiatric patients, all of whom had been in the hospital for less than one year.

2. The diagnoses of these 23 patients included: schizophrenia, 16; manic-depressive, depressed type, 2; involutional paranoid, 1; psychoneurosis, conversion hysteria, 2; and organic psychosis, 2.

3. The results in this group of 23 patients were as follows: two patients with psychoneurosis, conversion hysteria, responded favorably. Fourteen patients showed no change. Seven patients had aggravations of symptoms when therapy was completed.

4. Histamine therapy is ineffective in the treatment of psychiatric disorders.

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DREAM LIFE IN A CASE OF HEBEPHRENIA

BY BEN KARPMAN, M. D.

In a previous communication on the present subject,* the writer attempted to demonstrate the structure of the psychosis and the nature of mental content in hebephrenia through the medium of two cases, James A. Q. and Dr. X. Briefly, James A. Q. was a soldier who presented a picture of a quiet, passive individual, even though he expressed in a mild way some persecutory delusions. For the most part, his mental content, dealt with bizarre, delusional material which in totality may be regarded as grandiose fantasies centering chiefly around ancestral delusions. His sex life, after a brief excursion into some activity, came to a standstill; but the mental content revealed asceticism and incest, homosexuality and effemination, and over-evaluation of masculinity. In the center of the picture, there stood incest and father fixation with paranoid projections based on homosexuality, the whole mental content being markedly a case of regression. The second case is that of a 33-year-old white, male physician who showed a number of hypochondriacal delusions in contrast to James A. Q., whose delusions were more of a grandiose and compensatory character. Parallel to James A. Q., Dr. X. showed a number of genealogical delusions and also a very meager sex life. Homosexual fantasies and a homosexual conflict were present. In this case, the Oedipus complex was definite; and, here too, as in the first case, was a positively-toned attitude toward the father. In this case too, it was around the problem of incest and the implications that stem from it that the entire psychosis appears to have been built—in order, it seems, to square instinctual pressure with the demands of a cultured conscience. But whereas in the case of Q. the attachment to the father was definite, and antagonism toward the mother growing out of jealousy was correspondingly more vehement, such father-attachment was only lightly mentioned in the case of Dr. X. and, correspondingly, the subject of the mother was merely ignored.

Both cases appeared on study to be highly symbolical representations. In particular, the study revealed some very significant, even dramatic, differences—which may be regarded as being qualitative in character—between neurosis and psychosis. These dif-

*Hebephrenic fancies. J. N. M. D., 100:5, 480-507, November 1944.

ferences showed sex life in the schizophrenic psychosis to be strikingly different from that in neurosis. The nature and type of conscience and guilt reactions were acute and overwhelming in the schizophrenic psychotic, as compared with the neurotic. These differences also concerned the nature of the repressive mechanism in the two states; the function that delusions perform for the psychotic as against mere fantasies of the neurotic; the types of symbolization effected in the two states; and the loss of the sense of reality, a loss only partial in the neurosis but so striking and complete in the schizophrenic psychosis, with its autistic preoccupation and consequent intellectual deterioration, which is basically emotional deterioration.

While the study thus brought out a number of interesting features, one important aspect was lacking. The writer had no dream material available in the two cases. Such material is often exceedingly useful in understanding unconscious mentation. The case to be presented forthwith, also one of hebephrenia, has supplied a number of interesting dreams which, on the one hand, support the first findings and on the other hand, throw additional light on the structure of the hebephrenic psychosis and the nature of the mental content found therein.

1. The Structure of the Psychosis.

A Delusional Theory of Evolution. Lt. B. stood high in his class at Annapolis and for four years after graduation appeared to be getting along well but then broke down. The writer will omit, for the present, his personal history preceding the illness as not being relevant to the present discussion. So much of it as may be pertinent will be brought in later.

His genitalia, said the patient, are connected with his brain. During each "cycle," he acquires a new brain. Each time, the former brain is gotten rid of through ejaculations; and from the color and consistency of these he can tell the state of development. For instance, each time the "color becomes whiter and of finer consistency," it shows the brain is nearing perfection. When the color becomes white, then this state of perfection will have been reached. Each time after the completion of a new brain, there is a period when this "urge" is not present, and he is not aware of any genitals unless he touches them. The end result of all this will be "stronger and more potent sexual organs" and then the connection between these organs and the brain will be severed.

On formal examination his answers were relevant, coherent and fairly free, but he was not fully in touch with things. He showed considerable blocking and exhibited numerous mechanisms. He admitted having heard voices on two occasions—but merely heard his name called, each time in a different voice. He had no insight and was preoccupied with his "evolutional theory." He was correctly oriented in all fields; remote and recent memory were defective; intelligence tests were satisfactorily performed; calculations were good; he disclaimed much knowledge of or interest in current events; general information was only fair, considering his advantages.

Mental Telepathy. Later the patient laughingly denied his previous delusions, but immediately gave expression to others dealing with "mental telepathy."

He said that while he was in California he began to notice that people were reading his mind; their expressions would change rapidly, and "dirty thoughts" would then come to his mind. He appeared to be somewhat depressed, said that he was "despondent" and "miserable"; that his troubles "began six weeks ago" and that he was "helpless as a baby." He said that he had impulses to curse everybody—his mother, God, etc.—had thoughts of fellatio and of men eating their excreta. He thought that there emanated from him a "power" that had caused unknown suffering and numerous accidents. "All accidents to everyone are the result of my having lived, of my being in the world." He thought that because he had caused so much misery he should be taken out and burned at the stake or hanged.

Religious Training. In discussing his early history, little was brought out indicating early religious training and interest, although here and there an allusion to some religious statement by a relative left one with the impression that such religious matters as he heard about in childhood were mainly connected with ideas of punishment. Sometime later, however, he appears to have had at least one religious contact which exerted a considerable influence on him. The individual involved is referred to merely as "the Bible Man" (we do not know exactly who or what he was) and the patient's account of him runs substantially as follows:

About five years ago, in the home of a widow with whom he was having an affair, he met "a very old man, aged 88 years, of short stature, who claimed to have been a professor of Bible work at Oxford and a profound student of the Bible. He claimed to have studied it especially for three years in some monastery located on the Island of Patmos, in the Mediter-

ranean Sea. . . . This man gave a course in Bible work—$100 for 16 lessons—trying to interpret the meaning of the Bible by concentrating on a black spot, the size of a dollar. This was set up on a wall and read through the nostril—the left nostril was pressed with the finger while through the other nostril the interpretation was breathed in. This was a way to develop the right and left sides of the brain. The Bible man taught that there were 14 senses, namely, seven physical senses and seven "illuminated" senses. The physical senses became affirmation, touch, hearing, etc., all being represented by colors, green, red, yellow, blue, etc.

Of the seven physical senses, five were the usual senses, plus the sense of the blood and the sympathetic system. In the course of time the physical senses became "illuminated" senses. The brain is divided into 84 parts, each section representing some special sense—music, literature, art, etc., and each sense being represented by some particular color. The sense of smell eventually became something else; the temple of God was in the brain of the mind; he tried to connect evolution with the Bible. From the Bible he interpreted adultery as meaning sexual intercourse "with people of inferior standing, not necessarily concerning married people." This led him (the patient) to commit adultery with a married woman. The Bible man further taught that sex life was not meant for foolishness and should not be wasted. But he did not talk much about sex, because sex was above his work. Later the patient used to meet this man now and then: "He told me once, 'When you come to the I. M. of the law . . .' He did not finish the sentence, and I never understood its meaning."

Sex Life

He appears to have received no sexual instruction. He says "that he knew nothing of sex matters" until about the age of 14 or 15, when, through other boys, he learned about masturbation. He also says that when he was about 12 years old he developed the fear that, when the time came, no pubic hair would grow on him, and that he was "greatly relieved when finally it did appear." Both of these statements seem to indicate that he received no sexual information except through the usual surreptitious channels. Nevertheless he seems to have been sexually precocious, for he relates a number of childhood episodes involving sexual curiosity.

Exhibitionism. At the age of seven or eight, he had something like an exhibitionistic episode with a little girl. The girl reached over to play with his penis. He does not recall his reaction to this episode, but remembers that his father observed them and that he got a spanking.

Homosexuality. When he was eight or nine years old, he saw his brother and another boy, who had his penis out and tried to get his brother's out, too. The patient stopped this.

Zoophilia. When he was 10 years old, encouraged by other boys, he touched a horse's penis—barely touched it. The horse ran away. Once, out of curiosity (age not stated), he played with a dog's penis until the dog had an emission. He claims this had no effect on him.

Voyeurism. When he was about 12 years old, out of curiosity, he peeped through the keyhole of the bathroom door and saw the naked breast of a woman visitor. He was disappointed at the sight and never cared to peep again.

All of the incidents mentioned occurred before he was 14 and before he had learned about masturbation. The latest age mentioned is 12. In connection with these incidents, we note the repetition of the word "curiosity." Although he had apparently learned nothing about sex, he was certainly curious about it, and had already developed a number of inhibitions concerning it—he stopped the mutual exhibition of another boy and his brother; he was "disappointed" by the sight of a woman's naked breast. This "disappointment" may not have been altogether a matter of inhibition, however, but may have been determined by a preconceived phallic attraction.

Now let us continue, topically, the account of his sex life from the age of 14 or 15 when he first learned about masturbation.

Masturbation. After he had learned about this from other boys, he indulged in the practice on an average of about once in seven to 10 days. Following his first admission to the hospital, however, he often masturbated three times a day, and at least once every three days. Masturbation was "easier on him" than intercourse with women, but it, too, would leave him tired. The practice was accompanied by fantasies of fellatio with women, and also by fantasies of normal intercourse. He sometimes masturbated between his own legs, by pushing his penis back between his legs and then rubbing it with his legs.

It was to avoid masturbation that he would visit prostitutes. He was often obliged to masturbate at night in order to sleep. But he asserts that he got no pleasure from the practice; that on the contrary it was painful, just as intercourse with women was. It was deadening, too; it would take him a week to get over it. The whole

thing was repulsive to him, and afterward he felt low and depressed.

On October 25, 1925, he said, "Last night I masturbated to relieve the strain. It did relieve in a way, but weakened me."

In an interview on November 2, 1925, he said, "The last time I masturbated was about two weeks ago. Have not done so since then, nor have I had any nightly emission. Sex desire has left me more or less. I hardly ever think of sex now."

In a later interview he said, "I began masturbating at 15. It had a more or less deteriorating influence on me."

Nocturnal Emissions. During one of the early interviews he said that he used to have nocturnal emissions fairly frequently—"not so much now, last night's was the first one in a year." These were often, though not always, accompanied by sexual dreams, in which the situation would be that of lying down with a girl, kissing her or having active relations. He never dreamed of fellatio or other perverted practices. It will be seen, however, that fellatio and other perverted practices played a large part in his daily obsessive sexual thoughts.

Homosexuality. When B. was 13 years old, a YMCA secretary—a man about 45 years of age, married, with three children—visited his home. This man induced him to sleep in his bed and while they were together he began to fondle the patient's genitals as well as asking the patient "just to touch his." The patient refused to do the latter. The patient had an erection, but no orgasm as far as he can recall, was disgusted with the whole thing and never thought of it for years. When he was 22 years old, a friend visiting the house, tried to play with him, but the patient would not let him; the whole thing dispirited him.

When he was 14, B. had a pederastic episode with his younger brother, nine years old. He assumed the masculine role. There was no satisfaction or pleasure connected with it, certainly less than from either masturbation or intercourse. At 15 he had another similar experience with another boy, from which he derived but little or no satisfaction—did it "just out of curiosity." Since then he had no further pederastic episodes with boys.

A few months before starting therapy, he again chanced to sleep with the YMCA man, who "played with" him. The patient had an emission. It "burned." He was very disgusted afterward. See his "general attitude toward sex," in the following.

Heterosexuality. His first heterosexual experience was at the age of 15, and occurred because he had been told by another boy that it was the proper thing to do. Not only was he not satisfied with the experience; he was, in fact, so disappointed that he made no further attempt in this direction until he was 21. During the six intervening years, his sexual experiences consisted of occasionally petting and caressing girls—this also because he had been told that it was the proper thing to do. He would go through this procedure without any feeling; in fact, he would be quite bored by the whole business.

When he was 20 years old, he became acquainted with an aggressive young widow, who induced him to enter into intimate relations with her; but, from fear of conception, these relations were in the form of pedication, and he enjoyed them very much more than any other type of relations. Their association continued for almost a year, and during the first two or three months he would see her at least every other night.

In connection with this episode with the widow, one perceives what appears to be a considerable element of rationalization. Their relations were pedication, and he "enjoyed them very much more than any other type of relation." The reason which he gives, however—fear of conception—can hardly be accepted at its face value. It would appear rather that this reason was given to justify a procedure which was to him more gratifying than normal intercourse. One recalls his pederastic experiments with two boys (one of them his younger brother), which he claims were not satisfactory; and also a "forgotten" incident at a very early age of his father giving his mother an enema (see the following). It is strongly suspected that this pedication with the widow was to him a psychic reproduction of that earlier scene which had so fascinated him. His relations with the widow were so satisfactory that "during the first two or three months he would see her at least every other night."

Some time later, he met a young woman with whom he kept company for two years and whom he was planning to marry, "but she married someone else before I got around to her. I was pretty well broken up when she got married."

One is inclined to question the genuineness of his matrimonial intentions, although he himself probably regarded them as genuine, or the sincerity of his grief when this woman married someone else. It is altogether likely that it was his lack of aggressive interest

which caused her to look elsewhere. Part of the reason for questioning his statements in this connection will be found in his account of his relations with prostitutes; for he says that when going with a prostitute he would use a protector, for fear of disease. It was difficult for him to get an erection, the woman would have to "play with him for quite some time," sometimes for two minutes. The orgasm and ejaculation would often be so quick that some women remarked that the act was altogether too quick for them to get any satisfaction out of the relation. However, at other times reaching the orgasm would take a longer time. At no time, however, was there any pleasure connected with it. No woman ever appealed to him.

The last statement is particularly significant and, with a single possible exception, undoubtedly true—"No woman ever appealed to him." In spite of his inhibitions where homosexuality was concerned, it will be found that, when he became psychotic, the greater part of his mental preoccupation centered around homosexual practices, and that on one occasion he was discovered in an actual homosexual relationship. The single possible exception to his statement is probably represented by his mother toward whom, it will be seen, he entertained incestuous fantasies.

He describes another heterosexual relationship as follows:

"Four years ago I became acquainted with a married woman; next occasion was that we were in a company of other people at a ball game. She sat next to me, kept on pulling my arms, getting closer and closer to me—got me excited. Going back in the automobile we sat in the back seat. I was playing with her leg—she did not discourage. I had an erection but no emission. I don't recall whether I masturbated on coming home. Sometime later, I don't recall just how long, we met again in her sister's house—I took her to a hotel where we stayed together about two or three hours. I went with her several times. The erection and orgasm were all right but I was scared a lot, felt guilty. There was not much loving or caressing. Sometime later, I was with her in a closed automobile standing in front of her house. It was dark—took a chance and had intercourse with her. It was very, very satisfactory. I had her again on board a ship in my stateroom —took a chance—went with her twice. My relation with her has been responsible a lot for my condition. She had a child later on. I wondered whether it wasn't my child. She said it wasn't, and I felt greatly relieved. Yet during my sickness it came to my mind that it was my child. I was frightened and worried, and it has sat on me heavy ever since."

His reaction to this relationship was mainly one of guilt, which reaction is indeed the predominant one in his mental disturbance. We observe that he describes at least one relation with this woman as "very, very satisfactory," which would appear to contradict his statement that "no woman ever appealed to him." Presumably, a woman appealed to him under certain specific conditions which fulfilled, in one way or another, some fantasy requirement, the nature of which we do not know.

He recites still another heterosexual experience:

"In the Fall of 1924 I met a young woman. She was 26 years old, short in height, medium build, brunette. I had a kind of half-relation with her on the ground. I don't believe I got it in. I worked to get her to go with me. There was some resistance—not much love—not much satisfaction. It worried me afterward."

Fellatio. When he was 24 or 25 years old, he had a fellatio experience with a woman. He enjoyed this, liked it better than intercourse. However, he had no further experiences of this type with women. He thought this act was unnatural.

This was typical of his reaction to sex generally, which represented a continual struggle between impulse and inhibition.

General Attitude Toward Sex. He maintains that anything sexual is disgusting to him. "I hate it and get no enjoyment out of it. I feel disgusted when people talk about it." (This statement, however, was made during his psychotic period, when guilt was his predominant emotional reaction, and when his obsessive ideas were the source of continual mental conflict.)

Personality Make-Up

The general personality make-up of this patient is reflected in his interviews with the psychotherapist, partly by retrospective statements concerning his early development, and partly by psychotic expressions embodying gross exaggerations of normal personality trends. The latter are, of course, entirely disproportionate to reality, but they nevertheless furnish an index to fundamental personality traits which were a part of his make-up prior to the onset of his psychosis.

Sensitiveness. He has been "sensitive" ever since he can remember. If he heard people speak about him, it used to hurt. A sarcastic remark during a conversation would hurt him. It was "hard to take." He was easily disappointed; the least thing would "shake

him up so," make him feel weak for a while. It would take him a long time to get over a disappointment. The least noise would disturb him. He never got used to gunfire in the navy. He easily became seasick. "Dirty" talk offended him.

When he was 13 years old, he was in a YMCA camp washing dishes and waiting on tables; and at this time, he was wearing glasses. They called him "four-eyes," and he was very sensitive about it.

Inferiority. A certain amount of inferiority feeling is necessarily reflected in the preceding notes on "Sensitivity," but one gets a further expression of it in the following notes:

He is pretty sure he couldn't satisfy a woman—he has no pep, no energy. His ideal of sex life is to do without sex altogether. In many respects he is physically different from other men. True he has hair on his chest, but his penis and testicles are smaller, there is no aggressiveness about him, no guts to fight anybody, even if insulted. Was much kidded about—called sissy, girls would tease him—said they could run faster, which is right, too.

Depression. From as early as three or four years of age he has had moods of depression, as if something would grip him. Then the feeling would lift. While depressed, he would be fearful, apprehensive, imagining all kinds of things. The depression would be so marked that he would lose all interest in life and would not care whether he lived or not; in fact, he wanted to die. These depressions would be followed by feelings of well-being, but the depressions would last much longer than such feelings.

His abnormal depression under the influence of psychosis is apparent in many of the statements quoted under other headings in this section.

Guilt. The manifestations of guilt are not so apparent in what we know of the patient's normal personality, but they are present in exaggerated form in his delusional content.

"I have committed every sin but rape and murder—adultery, theft, wicked thinking, swearing, profanity, cursing God, sex thoughts about my mother, my aunt. I have no desire for rape or murder—not even in the head. I was driving in an automobile with Aunt Johnnie; thought of intercourse with her, but made no advances nor said anything.

"I feel that the influence I exercise over people kills them. It is a slow death. Train wrecks, automobile accidents, etc., all result from my thoughts, from my state of mind. That's why I tried to kill myself."

With his usual sensitivity, one would expect to find an increased sense of guilt, but under the influence of delusion this is magnified

a hundred-fold. His single adultery, his insignificant childhood thefts, his occasional swearing, his fleeting incestuous or paraphiliac thoughts, become veritable obsessions of self-condemnation. He is so sinful that his thoughts are all-powerful, causing irreparable damage to other innocent persons. All public calamities are traceable to him. He is not only guilty; he is the very personification of guilt.

Fear. It would seem as if fear had always been present in the patient's normal personality make-up, at least the sort of fear which is more readily associated with the term "anxiety." He says that:

"I have always been afraid of snakes and reptiles of any kind; in fact, anything resembling a snake. Even the trees here give me the impression of twisted snakes; pipe lines in the bathroom give me the same feeling.

"I was always so easily frightened and upset, more especially if it was something unexpected. If a superior officer would send for me, it would give me a nervous feeling, wondering what it might be all about; my heart went into my mouth. Before the gun-fire I would be all worked up, tense and wrought up; after the gun-fire started, it would not be so bad."

In the hospital, his fear is obsessive—a definite phobia. He refers to "this terrible fear about mental telepathy, people knowing what I am thinking about—it is driving me to destruction. I can't see how it can be true."

The fear of death is also present. "I fear hell when I die."

On another occasion, fear is extended to nearly everything. "Fear got hold of me. I am afraid to go outside. I am afraid to close the door in my face. I am afraid somebody will hit me. I am just afraid of the future. Right now I am afraid to go on the ward . . . I am just afraid to think of anybody."

Fear is sometimes one side of an ambivalent emotional picture:

"Sometimes something gets hold of me, a feeling comes over me. I don't think then of the past at all; my mind seems to be running away with me. Sometimes something grips and I feel fine; don't care what happens; seem to lose control of myself. Then again another feeling grips—I become fearful, scared to death, think of nothing but the very worst. One is the feeling of being arrogant, brutal, conscienceless, remorseless; the other is that of fear, cowardice. I seem to be cold sometimes with fear and cowardice in my heart. When I am warm, I am arrogant, seem to have no conscience, just complete brutality. Don't seem to be able to control it either. Can't understand how a man could be so destructive in his mind, such a way of reasoning. I use to think I had a sense of decency, honor, some sense of

fairness and justice. It is all leaving me now. Nothing seems to grip me except a desire to live in spite of everything."

Fear, as it is described in this passage, would seem to be a protective mechanism against aggressive impulses. The latter are undoubtedly exaggerated, like everything else in the psychotic state, and represent wish-fulfilling fantasies designed to offset inferiority feeling. Then the aggressive character of these fantasies terrifies him and he becomes "cold . . . with fear and cowardice."

Suicide. Suicidal ideas recur repeatedly during his second hospital admission.

"I often pray at night that somebody should please come and shoot me. . . . Before I left, Mother asked me to promise her that I will not commit suicide. I did not promise it, but her request keeps me from doing it."

A little later he says:

"I have had suicidal ideas for the last three years—more now than ever before. I don't think I have courage enough. I am a coward. Then, too, mother asked me not to do it."

Following a hospital conference at which ground parole was denied because of his suicidal expression, he said:

"Yesterday I was up before the conference for ground parole. They asked me about my feeling and I frankly said that I would like to go and throw myself in the river. They refused the parole, but I don't think I would ever make a real attempt. I no sooner think of that than my mother's request not to do anything of this kind comes to my mind, and then the whole thing falls flat."

With the increase of his obsessive thoughts, there develops an increased suicidal urge.

"The sooner I get out of the world, the better I'll be off. I thought of going to the river, but the agony of drowning is too great. Can't you please give me poison or a gun? I'll finish the thing myself. It will be a blessing to the world if I leave it—best for me and for all concerned. I am ruining my chances for future salvation. It is a terrible thing for me. You will do your duty by letting me kill myself . . . Please, doctor, get that stuff and let me die . . . I beg you, doctor, to let me have it. The sooner the better."

A day later it is the same story.

"I still entertain ideas of killing myself . . . I wish you would give me something to kill myself with. I am just a poor miserable wretch. The end is fast approaching. I don't see why I can't take the stuff before it is too late. It is no use in the world to go on. Surely you can give me something before it is too late to take me out of here—some quick-acting stuff—

can't you, doctor?—before I commit some terrible crime, cursing, turning back on mother and father. I don't even care now if it is painful. It will be less painful than the pain that is to come."

Referring to his idea of telepathy and that he is "the cause of a lot of sickness and death," etc., he says: "I don't see how to get out of it or throw it off except by suicide."

On November 21, 1925, at 6:00 a. m., he attempted suicide by hanging, having improvised a noose from the rope-like attachment to the electric fixture in his room. As he pulled the chair from under him, he fell to the floor and became unconscious. The rope broke, however, and he failed of his purpose. He soon regained consciousness, and there was a red mark on his neck. Following this attempt, he gave expression to some of the ideas of extreme inferiority and guilt which have been quoted under those headings.

Mental Content

The mental content includes compulsive ideas, obsessive sexual preoccupation, paraphiliac fantasies, hallucinations, and several types of delusion. Coincident with all this, one observes a peculiar kind of insight by which the patient is "almost persuaded" that many of his ideas are absurd but which nevertheless does not free him from their tormenting influence.

Compulsive Ideas. When he was first taken sick, "I thought that my fate depended upon playing cribbage, whether I lost or won it." "I began to count numbers, steps on the deck, walk seven times, smoke three cigarettes—all that nonsense." "I got the idea that I had to play cribbage all night to test myself; also thought that it was necessary for me to eat fruit."

Cursing. The patient says that cursing used to run a great deal through his head. When someone's name would come into his head, he would feel like cursing—any one of his friends, his mother, even his father. He cannot quite explain it, as he has "nothing against" anyone.

Associating to a dream on October 26, he says:

"My mother comes to my mind. Then the sentence: 'Damn my mother—c. s.' I just can't stop these ideas going through my mind. Other thoughts flash through my mind: 'God Almighty! Jesus Christ! I am in such a disorderly state of mind. 'Mother and Father. S. O. B.' "

Later during this same session, he once exclaims, "Good God Almighty!" and once "Christ Almighty!" These profane interjec-

tions are a part of the compulsive and obsessional thought process which characterizes his psychotic state.

At a slightly later date, he says, "If I see someone, I wish to curse him . . . I don't mean these things; they are just coming up involuntarily . . . I am unsettled now, cursing the doctors and all, although knowing only too well that they are doing everything they can for me."

Several days later, he entered the room much distressed and upset. The ideas that had been constantly going through his mind were "fear of death and hell, cursing God, Mother and other people, calling the Bible horse shit," etc. These compulsive ideas torture him. He says, "I can't go on living in this agony." He then launches into exaggerated self-condemnation, and passes to some of the pleas for poison, etc., quoted under the "Suicide" heading.

The next day he says, "When I am around someone, I curse them; tell them to get away. I don't realize it . . . I curse God and then I ask His forgiveness. I curse Mother—all kinds of names."

Still later he observes, "When I was small, Aunt Johnnie used to tell me that if one curses God, lightning and storm would come along and kill him; and here I curse God in my thoughts. I don't mean to."

Obsessive Sexual Thoughts. All kinds of abnormal sexual things are on his mind. Wherever he sees someone, the term c. s. pops up. Some time ago he was shown a lot of obscene pictures—naked men and women in different positions, engaged in all kinds of abnormal sexual activities. He was disgusted with them, yet later, especially after he was taken ill, the memory of them would be in his mind constantly. He would imagine himself in these various positions. These fancies were mainly of fellatio with a woman, but sometimes also with a man. There were no pedication fancies. These fancies were accompanied by erection, but did not produce emission. Sometimes they were followed by masturbation.

He has sometimes entertained incestuous fancies. Preceding his second hospital admission, while he and his father were on the train, they slept together. He was then imagining rubbing closer to his father, and shuddered at the thought of it.

He can't put his thoughts into words, but mainly it is "c. s., fancies-?, etc." that run through his mind all the time. He can't help it; he can't control it.

Coprophilia. Coprophiliac thoughts are part of his obsessional baggage. In an early interview he said that the first time he was in the hospital a fellow patient on the ward told of a certain passage in the Bible to the effect that, before the end of time the men will eat their own feces and drink their own urine. Somehow this has often been on his mind; he used to think of it, and even thinks of it now; it just runs through his mind against his will. It produces in him a "rotten" sensation. He imagines other people and himself doing it; and sometimes it even comes to his mind when he sits at the table.

At a later date, referring to "all kinds of sexual notions and ideas of perversions," he says, among other things, that "I also think when defecating, of my mother licking the opening of my rectum. It is terrible."

Fantasies. In an early interview, he says:

"During my sickness I had perverse ideas about my girl friends. I imagined having a harem and performing fellatio (cunnilinctus?) on all of them; had ideas of men and animals having relations; of fish cut open, the opening being used for sexual purposes. I pictured my mother in the harem, but entertained no perverse ideas about her."

The incestuous element is close to the surface here. He included his mother in his "harem," but "entertained no perverse ideas about her." Then why was she there? Repression is only partially successful. He puts her in an incestuous situation, but denies any incestuous thoughts.

In a later interview, he says that "when fellows stand alongside of me, I think of c. s., of fellatio, of them taking my penis into their mouths. I only *think* that; it is abhorrent to me." But it will be seen that, during a later hospitalization, he and another patient were discovered in this identical situation. These "abhorrent" sexual fantasies against which he struggles are, therefore, related to a very real regressive temptation. It was during this same interview that he said, "I also think, when defecating, of my mother licking the opening of my rectum. It is terrible." (See note under "Coprophilia.") It is the torment of these obsessive fantasies which impels him to beg for poison. It is in this same interview that he says, "I am thinking these bad things about my mother and the best friend I have, yet in my thoughts I hurt her and my father more than anybody else. I am ashamed to face her or anybody in the world." It was undoubtedly this incestuous con-

flict which later, when he had made considerable improvement, was responsible for his antagonistic attitude toward his mother, when she became afraid that he would strike her with his cane. His mother is associated with his most "abhorrent" fantasy; therefore he hates her, although he loves her in her maternal role. To a lesser extent, his father is also associated with an "abhorrent" homosexual fantasy, but this is fleeting and sporadic, and one does not anywhere encounter a corresponding degree of father-antagonism. Moreover, after his second admission he was almost continuously with his mother, so that the repression of his infantile fixation where she was concerned was more often called into play.

Hallucinations. On October 31, 1925, he said that "yesterday for the first time here," he heard voices. "It was really just the voice of what sounded like a man, but it was not human." The voice just called his name once or twice. But a year before, at about the same time, he had heard a voice which was not the same as this one, although not unlike it in some respects. It also sounded like a man's voice, but it was light, soft and soothing—a tenor. It seemed to come from far away, yet it was near. He heard it twice, once in the morning and again in the afternoon. His Bible teacher had once told him that a voice would call him when he came to a certain point in his Bible work.

During another interview he said that, when he was "first here," he used to feel something touch or tap his knees, although he knew no one was there.

In another place, he says that, when he was first taken sick, he "heard music that did not play." He does not elaborate on this, and it is not clear what he means by the statement, but it is at least suggestive of auditory hallucinations. It was the opinion of the naval medical officers that he had auditory hallucinations at that time, although this does not appear to have been established as a fact.

Delusions. The patient's delusional formation varied from one hospital admission to the next. It may be divided roughly into delusions of persecution; delusions of reference; somatic delusions; and delusions concerning mental telepathy. The last did not develop until after his second admission.

Delusions of Persecution. In August 1924, he "got the idea that people both on ship and on shore were trying, intentionally, to get me in trouble. One night I got the idea that they were trying to

throw me overboard." Referring to this period, he says also that "one night an idea flashed through my mind that several families of girls ashore were working against me. I felt there was something in the air. Fathers of girls I had known seemed to combine to do me harm, but just what it was I couldn't say. I just had that impression. Once the idea occurred to me that there was a committee on board ship, in the admiral's cabin, to decide what was to become of me, whether I should live, be thrown overboard or what . . . thought there was a trap set for me; . . . that there were some outside influences working against me; that I was the center of some disturbance. . . . One night I got the idea that the fellows on shipboard were going to take my bunk and throw me overboard. I kept up the idea for two or three days, and then it disappeared."

Referring to the period between his first and second admissions, he says:

"I remember while in California last September I was visiting the house of a friend. Going to bed, I locked my door for fear someone might come and steal something from me; also feared that some of the women in the house might come in. Next day, remarks were made about my locking the door.

"During the last year my whole trouble was fear—fear that someone was going to harm me or do something wrong to me. Mother told me that at night I would have nightmares, yell out in my sleep that someone was after me, would cry, 'They have gotten me.' "

Delusions of Reference. In the beginning, delusions of reference apparently went hand in hand with the delusions of persecution. Later they took on a special character and became associated with the persistent idea of his malign influence over others, e. g., he was the cause of public calamity, destructive natural phenomena ("wrecks, cyclones, earthquakes, windstorms"), suffering and death.

In July 1924, at a movie, he thought that things he saw referred to him; thought that he was involved in affairs; that friends of his were preparing a yacht in which he would ride around the world and have a good time. Referring to this same period, he says:

"A man I knew committed suicide because the admiral bawled him out for something; he was also disappointed over a love affair, and he killed himself. I had had an affair with a married woman and this man knew it;

and I thought that he went ahead and reported me and when asked for proof he couldn't produce it."

Presumably this was *his* explanation of the suicide, which, of course, had nothing to do with him whatever.

On October 12, 1925 he said:

"I am causing lots of people to become insane, accidentally, by reason of the power that leaves me and comes back—people are changing. This power causes railroad accidents, which is awful. My presence in the world is injurious to many people—I don't understand how; it is just an observation. . . . People's voices change when talking; sometimes they appear pale and drowsy, again peppy and full of life, and it seems to me that I am the medium of all that; it seems that I exercise some involuntary control over them. I know it to be imagination, yet it seems so true to me."

The last sentence is an example of the peculiar form of insight which the patient exhibits from time to time. He knows that many of his delusional ideas must be false, but that knowledge does not prevent his entertaining them.

On October 22, he said:

"I imagine people losing their teeth; babies are dwarfed; people have nervous breakdowns, etc.—all on my account. The blight seems to affect my two brothers; they, too, it seems are having physical and nervous trouble . . . I can't see how I could be such a freak of nature as to have all these powers."

The same peculiar flash of insight is again observable. He acknowledges the improbable nature of his ideas, but the ideas persist nevertheless.

On November 22, it is stated that "he is mourning over the fact that he is a blight on this world because people know what he is thinking about, and because it affects his own people—aunt, grandmother, two brothers . . . For the last five or six days he has not read any newspaper because reading of various accidents, deaths, etc., brings to his mind that they are all due to him. He does not know how in the world it can be true, yet he believes it." Here one glimpses the same conflict—insight without insight. He is compelled to believe something, although he "does not see how in the world it can be true."

On November 5, he said, "It seems to me that everything that happens has reference to me."

On November 18, he said:

"I feel that I am the cause of my mother's last sickness, my brother's heart trouble, my father's hemorrhoids. I am afraid other people know

what I am thinking about; that I have been the cause of wrecks, cyclones, earthquakes, windstorms, people dying and suffering . . . It is awfully hard to think that I don't belong to the world; that I am the cause of misery . . . I can't see how these things can be true."

He can't see how these things can be true, but that does not mitigate his suffering, for he cannot convince himself that they are *not* true.

On October 24, he said, "I have a peculiar sensation in my throat when I see other people doing it. [*Doing what?*] It makes me feel as if it has reference to me. It is foolish, I know to think so."

Somatic Delusions. On October 28, the patient said:

"My body does not seem to function right now; my bowels are not right; there is something wrong with my kidney; I do not have good control of my urine. After I get through urinating a few more drops come out."

It would perhaps be difficult to say how much of this is sheer delusion and how much of it is merely delusional exaggeration. Possibly these somatic complaints had some slight basis in fact, but his reaction is in keeping with his delusional idea that practically everything is wrong—physically, mentally and morally—where he is concerned.

Reference has already been made to a statement appearing in the official case record with respect to the patient's idea about developing a new brain. Nothing is said in his interviews with the psychotherapist about "growing a tail," although on one occasion he said that at the time of his first hospitalization, "I read an article about the spine, and I thought that my spine was changing." This was perhaps coincident with the statement made in the case record to the effect that he thought he was growing a tail. On October 26, he made some statements that perhaps had some relation to this delusion as well as that about developing a new brain, and these are mixed up with certain ideas about evolution which also involve some somatic aspects. He refers to the day he was transferred to a naval hospital from shipboard, and says:

"I got to masturbating; got to thinking about fellatio; continued masturbating from once in three days to two or three times a day. Got the idea of masturbating the old brain out and masturbating the new brain in . . . I became very thin; spine was sticking out; thought the spine was growing larger. Then I began to think of evolution; tried to trace my ancestry; thought I descended from a long line of kings; that the soul of President McKinley was in me. I looked in the glass, and it seemed that my features changed; now I looked like a fish, now like a snake or other

animal. Once I thought that I had sunk in height, that I had become six inches shorter."

Other Evolutionary Ideas. Referring to the same period as that covered by the preceding quotation, he describes retrospectively other ideas about evolution, which appear to be independent of any somatic feature. He says:

"After I was at Mare Island for two weeks, the idea came to me about evolution. First I conceived the idea that the soul of Adam had been in people from generation to generation, and that the soul of Adam was in me . . . Then I developed the idea that there were three ages of mankind, and that there were three Adams and that with the advent of the new Adam, the old generation died away. I was the third Adam, and this generation and everything living on earth would die away and a new generation would come in its stead. About the same time, I got the idea that my grandfather and grandmother (paternal) were the third Adam and Eve. This is obviously incompatible with the other idea that I was the third Adam. At any rate, my grandparents were the third Adam and Eve, originating somewhere on earth—I don't know where and how—and that with the new species coming, the old ones were dying out. These ideas of evolution continued for six months, until about August 1925."

It is interesting to note how the patient can discuss so objectively his past delusional formation, while, at the same time, he is the pathetic victim of the succeeding one. It was immediately after the foregoing quotation that he said, "Now I have other peculiar ideas" and went on to describe the terrible things which were happening to people "all on my account." He even recognizes these ideas as "peculiar" but is nevertheless dominated by them and suffers intensely because of them.

Delusions of Mental Telepathy. On October 24, 1925, the patient said: "Mental telepathy keeps on running through my head. It just scares me." What follows, however, is hardly what we think of as "mental telepathy," but is rather a sort of sympathetic identification with others who are the victims of unpleasant experiences. In this connection he says:

"It passed through my mind about Dr. H., who gives syphilitic treatment here—what a hard time he has with the patients—spinal punctures. I so easily put myself into other people's positions—a man condemned to death, killed or hurt, some severe punishment, being buried alive, put in a straight jacket. I picture myself going through all these experiences; even hearing someone talk about it or just reading about it in a book. Is it my selfish disposition, inflicting things upon myself?"

On October 29, he said, "People know what is going on in my mind; they know things from my past. I exercise a hypnotic power on people, over the whole world. The attendants hate me because of that." This is mental telepathy, plus something else. He follows this up by deploring his terrible state and pleading for poison with which to end his life.

On November 10, he continues in a similar vein.

"These ideas of telepathy, and that I am the cause of a lot of sickness and death; that I am controlling life currents on earth—they are impossible, yet I believe them . . . Anything that happens I involuntarily trace to myself."

On November 6, he said that he felt like a criminal because of the terrible powers he seems to have. He couldn't understand why he should have them.

These telepathic delusions, therefore, are of multiple effect. They are all, it would seem, connected with a strong feeling of guilt. People know what is going on in his mind; and that is distressing because his mind is primarily occupied with paraphiliac fancies. He identifies himself with whatever unfortunate sufferer he thinks, hears or reads about. This is presumably a form of punishment, because his own thoughts are so bad that he believes he deserves all these misfortunes himself. Then an egoistic element enters into the situation, represented by a certain omnipotence of thought. He exercises hypnotic power, controls life currents, is the cause of sickness, death, public calamity, natural phenomena, etc. While he speaks of this only in terms of distress, there must have been certain compensatory elements in it also, for, after all, only a pretty important personage can exercise such wide influence. But he never speaks of this; for the influence which he exercises is invariably malign and is presumably the result of his evil thoughts. These horrible things for which he is responsible represent an added source of punishment for his paraphiliac fancies, and his total reaction to these delusional ideas is one of depression, fear and panic.

Emotional Reaction. Under date of November 2, the following comments were made on the patient's emotional reaction:

"He is still dispirited, although, perhaps, not as acutely as before, and still wears on his face the expression of despair and suffering. There is no depression as a positive portrayal of emotion such as we see in a depressed manic, but there is a very marked lowering of the emotional tone,

almost, if not entirely, to the point of extinction as far as interests in the outside world are concerned; there is, on the other hand, a complete preoccupation with inner thoughts, over which the patient shows definite emotional reaction—intense agitation over his own, to him alone, peculiar problem. It is this extreme introversion with autistic thinking as the main ideational content that is no doubt responsible for this almost complete loss of touch with environmental interests. There is, therefore, definite emotional deterioration in the patient, if by an adequate emotional reaction we mean a consistent balance between inner and outside interests, for he is absorbed in his own inner problem and is quite oblivious or rather disinterested in his immediate environment. However, what emotional reaction he does show as regards his presumed problems, which to him are acute, is quite adequate, although obviously one-sided, there is, so to say, a deterioration of interests rather than actual deterioration. This sometimes gives on casual observation, the impression of emotional deterioration, because his outward emotional reaction does not appear proportional to the degree of suffering which he undoubtedly experiences when one talks to him a bit more intimately; but that probably is due, not to any emotional deterioration *per se*, but to that part of his basic personality equipment, which does not allow as complete emotional expression as one would expect from the ideational content given. There is, we take it, fully a purity of affect and in no sense any fractioning. Such emotional reaction in itself is not abnormal, since we find many normal people whose outward emotional reaction lags behind their actual emotional state."

Three days later, November 5, the following observation was made:

"Today the patient appeared in a slightly better condition although obviously still in quite a tensional mental state. He did not appear as uncomfortably restless as previously, rather more calm and composed. As before, however, he spoke very slowly, interrupted by rather long silences and he had to be constantly urged to continue: this, apparently, due to his absorbed mental state and the extreme preoccupation with autistic type of thinking. There is not any doubt that the man is suffering acutely and that his emotional reaction is fairly adequate, provided we grant him the premise that his imaginary troubles are real; they are real to him. There has never been any clouding of consciousness and it is only the intrusion of so many foreign ideas, enmeshed in an archaic framework on an otherwise clear background, that distorts the whole picture and gives the impression of splitting."

II. Dream Life

Superficially, the dream life of the patient appears uninteresting, for his dreams do not of themselves reveal the intensity of his emo-

tional life. He presents a marked contrast to the average neurotic whose dreams are full of his inhibited impulses and offer a clue to his psychological conflict, but whose conscious thought reflects the prevailing cultural pattern. The conscious thought content of this patient, however, is full of regressive fancies. They are constantly going through his head. His waking hours are occupied with thoughts about all manner of sexual perversions—homosexuality, fellatio, cunnilinctus, incest, coprophilia, etc.—while at night he dreams, for the most part, of normal relationships or of situations that are completely free of sexual elements. His dreams thus become a kind of wish-fulfillment and a defense against his antisocial tendencies. This situation, generally observable in the psychotic patient, is, in the writer's opinion, exactly the reverse of that found in a neurosis. This man's dreams, therefore, are tame in comparison with his waking thoughts and his dream life is more frequently a means of escape from his obsessive thoughts rather than the season of torment so often found in the case of a neurotic whose waking thoughts are under control but whose dreams show the regressive tendencies which he is otherwise able to conceal or deny.

There is a record of 26 dreams (29 when one includes the separate dreams of a single night). The largest group represents those which contain elements suggestive of homosexual interest, although every one of these dreams is doubtful insofar as any actual homosexual content is concerned. Heterosexual dreams (of which three are emission dreams) come second. There are a few anxiety dreams; a few paraphiliac dreams; and a few dreams about his parents. The patient's associations to these dreams have already been incorporated in the notes on his life history given in the foregoing. What follows are the dreams and the writer's comments.

Dreams Suggestive of Homosexual Interest

Dream 1. It is the period of the Revolutionary War. He is somewhere, probably in the country, at a soldiers' camp. He is alone with a few Revolutionary soldiers around him. He promises them to get coats and food. He was unable to recognize any faces. There were no women there, nor any army officials.

COMMENT ON DREAM. The only significant point of this dream appears to be the absence of women and officers (authority). His

associations have no relation to the dream itself, but merely furnish anamnestic data. From his associations, however, it would appear that this was an emission dream, although it is not so recorded, for he says, referring to emission dreams that "last night's was the first one in a year." He also remembers that when he was first hospitalized a fellow patient told him that a certain passage from the Bible read: "Before the end of time, the men will eat their own feces and drink their own urine." This has often been on his mind, and even now he thinks of it; it runs through his mind against his will. There is here a possible connection with the Revolutionary soldiers at a camp in the country, men for whom he promises to get coats and food. The idea of their privation furnishes a certain parallel to the plight of the men "before the end of time" in the Biblical quotation. "He was unable to recognize any faces" (feces?). The manifest dream content is simple and free from any element of anxiety, but the dream thought behind it is apparently regressive; and if it was in fact an emission dream, we may be sure that the underlying dream thought was exciting. The absence of women (the choice of a setting in which women would necessarily be absent) suggests a homosexual idea, while the absence of "officials" suggests the removal of restraint or control.

Dream 6 (October 20-21). "Dreamed I was to be sent as aide to a member of an embassy which was going to Spain. The entire dream took place in a vestibule or hallway, with four other men present. One of these men looked like Major Ketcham; one of them resembled a classmate of mine named Kincaid. He was about five feet, 10 inches high, heavy-set and stocky. Do not recall appearance of other man. The purpose of the party and the time and mode of departure were very vague. Suddenly these men appeared in a policeman's uniform similar to the uniform worn by the San Francisco police. The uniform consisted of blue single-breasted frock coat with turn-down collar as part of the coat, and straightout trousers. Do not recall the departure of these men to get their uniform. Upon their appearance I was in a dilemma as to whether or not I should obtain a uniform, and where I should go to get one. I woke up to write up the dream and then went to bed again. There was no emission."

COMMENT ON DREAM. The manifest dream content appears to be without significance. The only reason for reading any homosexual implications into it is the fact that it is concerned exclusively with men, with some physical description of one of them, and with uniforms, which are also described in some detail. There appears to

be no affect. The associations involve reminiscences of some past ambitions. Then he talks about his "guilty conscience" and relates various episodes with the married woman with whom he had had sexual relations. He attributes much of his present condition to these relations. Then he says, "I don't believe I am sexually strong enough to satisfy a wife. I have very small testicles. After having relations, I feel all tired out for a week or ten days afterward —completely worn out." This would appear to be a rationalization to justify a retreat from heterosexuality. (We know that the patient's waking thoughts are concerned with regressive tendencies; that his whole problem is one of regression; and that his sense of guilt centers about these regressive thoughts and not about his past heterosexual episodes, which only furnish an excuse for the guilt feelings.)

Dream 7 (October 21-23). "I dreamed I was back on the *U. S. S. Pennsylvania*. We were entering port, which one I do not recall. I was in my stateroom on the third deck when officers' call sounded. I came running up on deck, passing Major Wood (a patient at St. Elizabeths) at a place where mast was held. Running on deck I found the crew lined up for the coming to anchor. I took two puffs on a cigarette and then threw it overboard."

COMMENT ON DREAM. This dream appears to have a slight anxiety element but is otherwise without observable significance. Again there is no reason for calling it homosexual in character other than the fact that it is concerned exclusively with men. In fact the dream carries with it no particular affect.

His associations are concerned with his remembered ideas of reference which he developed on shipboard, and he tells us, among other things, that "I developed a peculiarity of pressing and pulling my nose" (masturbatory substitute?). He also thought that "the end of the cigarette would turn red, yellow, white, etc." A cigarette appears in his dream also. Probably his preoccupation with a cigarette was connected with unconscious ideas of fellatio. He recites past delusional ideas about evolution and also past Messianic delusions; then passes over to his present ideas about his responsibility for the various ills of mankind, as a result of which he has an urge toward suicide. And he concludes with a recital of ideas of practical deterioration, some of which suggest a preoccupation with regressive fancies related to coprophilia. "I am getting old; my hair is falling out; am getting physically weak. I

even smell like an old pole cat; the perspiration coming out from the pores of my skin stinks." But none of his associations have any apparent connection with the dream, which is merely reminiscent of an ordinary event in his past naval experience.

Dream 9-B (October 23-24). "I dreamed that I was going to an ice cream plant with a shipmate to order some ice cream. Do not remember who he was. We ordered the ice cream; do not remember for whom it was. Next I dreamed I was asleep in bed and some one pulled the cotton sheet out from under me. There was no emission."

COMMENT ON DREAM. This dream would appear to have a slight homosexual implication. We have a shipmate, ice cream, and some horseplay while the patient is in bed, which undoubtedly involved another male individual. His associations are concerned with asking his father for a nickel for ice cream and with working for an uncle in his soda-pop factory. The memory of an episode connected with this uncle, when the latter called his attention to a snake, leads to a discussion of his fear of reptiles, apropos of which he says that "pipe lines in the bathroom give me the same feeling."

Some of his statements are suggestive of unconscious preoccupation with fellatio. "If a superior officer would send for me . . . my heart went into my mouth." (A commonplace enough expression to describe nervousness, but probably with a special application in this particular case.) "I have a peculiar sensation in my throat, and when I see other people doing it, it makes me feel as if it has reference to me." (Other people doing *what?* He doesn't say.) His associations indicate a great burden of guilt. He puts himself in the place of other persons who suffer—"man condemned to death, killed" . . . "It is my selfish disposition—inflicting things upon myself."

Dream 11 (Tuesday, October 26-27). "I dreamed that I was on the *U. S. S. Pennsylvania.* We were steaming up a river in South America, destination unknown. I was sitting in my stateroom on the third deck. An officer whom I now saw for the first time, entered my room and we started conversation. He asked me if I wanted a job when we entered port. There was also referred to in this dream the matter of some keys. I don't know in what way, but it was important. The man was of medium height, sandy hair, regular features, rather heavy set. The job he spoke of consisted of unloading gasoline and oil drums when we entered port. On going up on deck I found ourselves in another stream about 50 feet from the one we were in and facing an opposite direction. The stream was too

narrow to allow navigation of the boat; in fact, because of its large size, it occupied space beyond the confines of the stream, particularly to one side. Could not understand how we got in there and how we were going to get along."

COMMENT ON DREAM. The dream appears to be insignificant; certainly there is no reason to label it homosexual beyond the fact that the only other person in it is of the same sex as the patient. The latter portion of the dream is suggestive of a symboiized womb fantasy. The outstanding feature appears to be "some keys." A key is frequently a phallic symbol. In the patient's associations, he refers to being hit with a baseball in the pit of the stomach when he was 12 years old, and says, "I thought at that time that my testicles were knocked out." Also in his associations, he recalls that in the dream "some officers went in swimming" (nude?). "One of them remarked that he was going to retire . . . come here and build a whore house." He recalls in connection with the beginning of his mental disturbance in 1924, that "one night I got the idea that the fellows on the ship were going to take my bunk and throw me overboard" (disguised idea of homosexual assault?). He says, "I am not thinking of sex and sex perversions now as much as I used to."

Although the dream itself, therefore, contains nothing of a homosexual character, it is concerned with regressive ideas under the guise of ordinary events. This is partly indicated in the dream by the "opposite direction" in which the ship was found to be facing.

Dream 19 (November 12). "I dreamed that I was going to the toilet in the back yard of a two-story house and upon arriving there I found myself in the midst of several hen houses. Suddenly I saw an old friend of mine sitting in the back yard of this two-story house. Eagleton and I roomed together on the *New Mexico* for two years. He invited me on a two days' fishing party, starting that night. On the way out, at a cross-roads, another car ran over my fishing tackle. Eagleton is of medium height, black hair, and heavy-set."

COMMENT ON DREAM. There are certain coprophiliac suggestions —a toilet and hen house. Again we have the physical description of a man, who invites him to go on a fishing party "starting that night." Association develops the fact that he spent a good deal of time with this man, who "used to be nervous and fidgety." Later on he says: "I am nervous and fidgety all the time," seemingly identifying himself with his former friend. He says, "The fishing

party reminds me of chicken in California—an interesting sight—heat coops. It seems like we were going fishing, riding in a car. Somehow it seemed that the fishing pole was an inch in diameter." We recall that in the dream "another car ran over my fishing tackle" (disguised representation of homosexual assault?). This also reminds him of an actual incident in his boyhood when two other boys ran over him on bicycles (being run over appears to be similar to the picture so frequently encountered in dreams of women of being trampled by horses, etc., a disguised symbol of sexual assault).

In nearly all of these dreams, we observe that the manifest dream content is harmless and trivial and ordinary, and that there is no apparent affect (a situation altogether different from that which exists in the dreams of the neurotic, where the circumstances, even though disguised, are suggestive of strong symbolic significance and where the affect is usually great). This man exhausts most of his affect in his daily fantasies, and at night dreams of ordinary, apparently normal events in which the regressive content is so heavily disguised that it offers no disturbances.

Dream 25 (November 16). "I dreamed that I was in Waco, Texas, and it suddenly dawned on me to return to duty. I had no orders but decided to go to San Diego which I imagined was at the mouth of the Brazos River. I went on board a hospital ship, *Relief*, which was lying at the dock. The dock was a T-shaped dock, something like the dock at Annapolis. The ship got under way and the next thing I found myself in the destroyer force office at San Diego talking to a senior lieutenant. He was of medium height, rather slenderly built, had blonde hair and ruddy complexion. I asked him for orders and he, in turn, asked me for the pay appropriation out of which my pay came. I told him it was a 5 — nm 1-k."

COMMENT ON DREAM. There are no associations to this dream. Once more we have the physical description of a man. These repeated physical descriptions focus attention on the male anatomy and are often the only thing in the dream which suggests the possibility of any homosexual interest. We have here emphasis on "a T-shaped dock" which perhaps carries a slight phallic significance. The transition from "a hospital ship, *Relief*" to one in "the destroyer force" is suggestive of increased conflicts.

Dream 25-B (November 17). "I dreamed I was doing electrical work on a battleship which was somewhat similar to the *U. S. S. Texas*. I happened to pass a motor generator whose bearings were running hot. The location of this generator corresponded, in some way, to the southwest

or rather northwest corner of a house where I used to live. I took off the end plates of the motor generator. About that time a friend of mine, Mr. Eagleton, whom I roomed with a while on the *U. S. S. New Mexico,* came along. I replaced the plates in the end of the set and started up the set. No emission."

COMMENT ON DREAM. The outstanding feature of this dream for which there are no associations, is the removing and replacing of the plates on the end of a motor generator. He replaces them when a friend "with whom I roomed for a while" comes along (that is, the same friend who invited him on a fishing party in an earlier dream) and then starts up the set. This symbolization is not clear, but is at least suggestive of erotic significance. The only other person in the dream is a male friend. The generator "corresponded in some way to the southwest or rather northwest corner of a house where I used to live." The bearings of the generator "were running hot." There is apparently a childhood association involved which is not clear. Electrical apparatus is frequently associated with sex in dreams, as are ideas of electrical influence in delusions. We are vaguely justified in calling this a homosexual dream, although there is nothing sexual at all about its manifest content.

Heterosexual Dreams

Dream 2 (October 15-16). "I dreamed that I was to be married. The affair was arranged by my father—it seems that he insisted on me getting married, not that I particularly wanted. I did not know who the girl was until after the ceremony. She was more of a brunette, dark-complexioned young woman about 23 to 24 years of age, brown hair and eyes, average height, a little heavy set. After the ceremony my father, myself and the girl were to go east. They boarded the train, but somehow I missed it, but managed somehow, by getting on at another station to catch up with them. I don't know how I did it. We were all the time on the train, but I stayed away from my wife for a period of time—a day or two—and then went to her sleeper. She had a bathing suit on. I started having relations with her, but barely started when I woke up, having a nocturnal emission. It was probably about 4 to 5 o'clock in the morning."

COMMENT ON DREAM. There were no associations to this dream. While it is a heterosexual dream insofar as its manifest content is concerned, it exhibits a great deal of material suggestive of homosexual conflict. His father arranges the marriage; the patient does not even know who his wife is until after the ceremony; he misses the train; and when he does catch up with it, remains away

from his wife for a couple of days. His wife is wearing a bathing suit. Everything is calculated to impede and delay the ultimate heterosexual relation, which seems to take place from a sense of duty rather than because of desire. He has a premature ejaculation in the dream just as he invariably did in waking life whenever he attempted relations with prostitutes.

Dream 3 (October 16-17). "I find myself in an apartment of a girl whom I have known before. I cannot say how I got into the apartment, nor can I recall who the girl was—but she was someone I knew before. The apartment seemed to be a nice place. She was a young woman, blonde, slender in build, medium height. We just talked—can't recall what we talked about. Not through her telling me, but in some way, I got the impression that she became a prostitute. We did nothing in a sexual way, not even kissing or caressing. Then I went to see the other girl. She was tall, slender and brunette. Her apartment was a number where last digit was 5. I just talked to the girl and then left. Nothing transpired between us. Either after that or sometime between these periods I went down town. I did not immediately wake up from this dream, but shortly after that. There was no issue nor do I recall any emotional reaction to the dream. The whole dream is very vague and many details are lacking."

COMMENT ON DREAM. Here, there is a heterosexual setting, but this is certainly not a sexual dream. Associating to the dream, the patient complains of the "peculiar ideas about sex abnormalities" which keep running through his head. He recalls red light districts in Panama; then talks about a widow with whom he went for one year, after which she married someone else; also about another woman with whom he went for two years, when she also got married. He was "pretty well broken up" when she got married. He says: "This is really what started my trouble." He also mentions some money difficulties in the navy in connection with his mother's allotment, involving strict regulations. (These circumstances are not clear.) The principal emphasis in the dream appears to be on the fact that the girls became prostitutes. Guilt and sex are intimately associated. The girls represent sex; he has nothing to do with them, but he thinks of them only in terms of prostitutes.

Dream 4. (October 18-19). "I find myself in bed with a girl, both having our clothes on. She was of slender build, medium height and blonde. Using my hand, I played with her organs until she had an orgasm. She, too, played with my organs without, however, obtaining an orgasm from me; then I awoke. There was no emission."

COMMENT ON DREAM. In this dream there is a sexual relation, but it is inhibited and confined to preliminaries. He and the girl both have their clothes on. Their activity is confined to masturbation. He doesn't have an orgasm, even in the dream. His associations include a recital of the ideas already mentioned in the account of his hospitalization—that he is responsible for railroad accidents, is causing people to become insane, that his presence in the world is injurious to others, etc., etc. He has some insight into the delusional nature of these ideas, but is nevertheless unable to control them. The Oedipus factor is clearly indicated by his statement "It splits my own family . . . I feel that I am a detriment to both sides. It breaks my poor mother, and that is what hurts me most." (His thoughts do injustice to his mother.) Now he recalls what appears to have been a traumatic episode.

"When I was about four or five years old, I saw my father giving an enema to my mother. It seemed to me that she had a penis like a man. That's why for a long time I did not know that there was any difference between man and woman. I forgot about this incident until the day of my sickness."

Here certainly is the idea of the "phallic mother" which may have an important bearing on his homosexual development. He continues:

"During my sickness I had perverse ideas about my girl friends. I imagined having a harem and performing fellatio [cunnilinctus?] on all of them. Had ideas of men and animals having relations; of fish cut open, the opening being used for sexual purposes. I pictured my mother in the harem, but entertained no perverse ideas about her. When I was at home, my room was separated from Mother's by a curtain. I feared that people might suspect us of having relations. During my last sickness, when my mind was awhirl, I did have ideas of having relations with my mother. I might have been poisoned by someone—don't know by whom. I had peculiar ideas about my birth; sometimes I feel I am not the son of my father."

The quoted passages show very clearly the accumulated burden of Oedipal guilt which the patient carried, with all of its bizarre ramifications. One also observes the remarkable contrast between the comparatively innocent character of his dreams and the perverse sexual content of his tormenting thoughts when he is awake.

Dream 14. "I am in a room and there is a girl stenographer writing on a typewriter. She was of medium height, rather tall for a girl, blonde hair, slender, rather pale. I don't know what I was doing, but I believe I was doing some kind of executive work, but can't recall the nature of the work.

There was somebody else in the room—I don't know who he was or what he was doing. I believe he was typewriting. Following this dream I had an emission, which woke me up; it was a pleasant dream."

COMMENT ON DREAM. The manifest dream content has no sexual element; nevertheless B. had an emission. "There was somebody else in the room. I don't know who *he* was or what *he* was doing." (Italics the writer's.) This appears to be the key to the dream, which is really homosexual rather than heterosexual in character. Who *he* was and what *he* was doing are forgotten. He says, "I don't remember what relations we had to bring about the wet dream." (A tacit admission that he did have some kind of relations with some one.) He recalls early ambitions, and remembers the room he had when he spent part of the preceding summer with his father. "I don't think there is any companionship that I enjoyed more than that of my father and mother." (Was his real reaction to their separation one of guilt because of the Oedipus situation?)

Dream 17 (November 10). "I had some dream about Mrs. F., the charge nurse on the ward. It was something about the routine in the ward. It was not anything about sex, and there was no emission."

COMMENT ON DREAM. He recalls that he once grabbed his charge-nurse by the arm. "I was just feeling good and didn't mean anything by it. Later I took a dislike to her." (Guilt reaction.) He continues talking about his "ideas of telepathy" and says, "They are impossible, yet I believe them."

Dream 21 (November 14). "I dreamed that I went into a movie in company with a girl who lives in Summerfield, Alabama. This girl is short, rather heavy-set, blonde and has a round face. This building was somewhat like the auditorium of Hitchcock Hall. We went into the balcony of the movie, about six rows from the front. This row had a very high back—about five feet I should say, and a narrow seat about eight inches. About the time we were seated a fight started in the Negro section, which was in the back of the balcony. No one seemed to interfere with the fight. There was no emission, although there was an erection."

COMMENT ON DREAM. Again the manifest dream content is without any sexual element. Sex is undoubtedly represented by the fight in the Negro section with which "no one seemed to interfere." Although he had no emission as a result of this dream, he did have an erection. Associating, he recalls going swimming with a Negro boy. "I ducked him and nearly drowned." Thus the homosexual element appears again. It is the memory of swimming with a

Negro boy that excites him—not being with a girl at the movies. He remembers that a man living next door to him once fired a shot at some Negroes (the fight in the Negro section). Shooting is also suggestive of sexual assault. When he ducked the colored boy, was he sexually excited? He also says: "I remember 1915—walking along the street—middle-aged man—yellow [woman?]—scared and left him." (Why "scared? Was there some suggestion of a homosexual advance?)

Dream 22 (November 15-16). "I dreamed I was in a house of prostitution. Remember four women in four different rooms. I witnessed an intercourse between a man and a woman in one room. The man was of medium height and weight and had very black hair, which was combed pompadour style. Do not remember anything at all about the woman. As a result of witnessing this intercourse, I had an emission."

COMMENT ON DREAM. He witnessed intercourse between a man and a woman and had an emission. Concerning this, he says: "It seemed that the man was so placed on the woman that his whole body from the lower ribs up projected over the woman's head." Then it couldn't have been normal intercourse. The woman must have been performing fellatio on the man.

Dream 26 (November 18). "I dreamed I was standing on top of a three-story building in a city which seemed to be Dallas, Texas. Suddenly an animal or a figure resembling in shape that of a bat, but heavily set, with very heavy trunk and wings, came flying down the street about on a level with the top of the building and alighted on the ground about three blocks further. As soon as it alighted it changed into a woman of medium height, rather slender, black hair and somewhat sharp and defiant features.

"The bat-like animal was brown in color; the body was that of a coarse creature. It didn't have wings or feathers, but heavy, scaly arms at the side. It seemed that the skin was that of a crocodile. The woman was not human, a peculiar creature of some sort, maybe a cross between a human and an ape. I remember her saying something about men, but I forget now what she did say; it was something derogatory. She said it to a crowd that gathered after she alighted. I was present in the crowd, although I don't know how I got there. She alighted about three-four blocks from where I was. She had a dress on, a skirt that came up to the hips and blue in color, and a shirtwaist on, which I believe was red; and a black felt hat; she had stockings and shoes on, but don't remember looking below her knees. Her face looked like that of a girl I knew several years ago. Woke up thinking I had an emission, but there was none."

COMMENT ON DREAM. He thought he had an emission but there was none. The dress clearly embodies his fear of sex. The woman

is an inhuman creature, part bat, part crocodile, but her face reminded him of a girl whom he had known. He recalls being on top of a building looking at the city; and also a girl who went to the top of a building to look at a fire which was in his father's house. (Fire is passion. The woman reappears in the dream as a frightful creature because the memory of her is associated with thoughts of sex.) The girl whom he is reminded of by the dream woman is one with whom he used to go driving. "She was a good and fast driver, and when driving with her my heart jumped." (Relation of motion to sex.) He continues with the idea that he is responsible for other people's sickness, including "my father's hemorrhoids." He also recalls an airplane ride during which he had an intense desire to urinate—"bladder bursted, or nearly bursted." (Relation of motion to sex; substitution of urine for semen.)

Anxiety Dream

Dream 12-B (October 27-28). "I dreamed of three figures—three corpses standing up. One was five feet, six inches tall, the other five feet, nine inches, the third, five feet, 12 (six feet) in height. They all had the same face. They were the same person in different attitudes. The figures had hollow-drawn places on their cheeks around the mouth; they were all pale cadaver looking. I woke up from this dream with a start, frightened. There was no issue. This was just a snatch of a dream."

COMMENT ON DREAM. This is an anxiety dream. Presumably the three corpses are multiplications of himself. His associations have almost no relation to the dream itself, but reflect his continual state of mental suffering and a great deal of his delusional content which is largely a projection of his guilt feelings onto his environment. The dream is one of the few with affect: He woke up startled and frightened.

Dream 13. "I am all alone and deserted and I came to a terrible end, cursing God, thinking I am crucified, burned, going to destruction, then was left alone in the open."

COMMENT ON DREAM. An anxiety dream which embodies the idea of punishment for his sinful (paraphiliac) thoughts. It is mainly a reflection of his waking delusions, which it continues, on this occasion, even in sleep.

Dream 20 (November 13). "I dreamed that I was getting ready to take an examination in steam engineering at the naval academy. I was somewhat nervous about it because I was not prepared for it. My seat in the classroom was in the second row from the left and the seventh seat from

the front end of the row. Do not remember the instructor's name or his description. The examination questions were mimeographed on paper and each student received a separate set of questions. One of the questions was: 'What pumps are used to empty a ship which has sprung a leak, or been in collision?' "

COMMENT ON DREAM. He says "the ship which has sprung a leak or been in collision." His nervousness in the dream is a repetition of his actual feeling whenever he took an examination. Examination suggests self-examination, which is intolerable, because of his repressed paraphiliac and criminal impulses. Referring to examinations at the naval academy, he says "If I did not know a question, I would use my imagination to finish it." Apropos of "imagination," he remembers that "I would often imagine that I was to be hanged." (Punishment for repressed impulses.)

III. SUBSEQUENT DEVELOPMENT

The following data from the official case record continue the account of the patient's career in and out of the hospital up to the time of his death.

At a conference to consider ground parole, he stated that he wanted to go to the river and jump in. Parole was denied.

On August 13, 1926, he and another patient were discovered in homosexual relation (fellatio), he being the passive partner. At this time he denied hallucinations or delusions, but admitted having had them. He was described as being cross and irritable with his mother when she visited him; and she said that on one occasion she feared that he was going to strike her with his cane. He was also reported as giving voice to obscene expressions and approaching women with sexual suggestions, for which reason it was necessary to prevent his attendance at Red Cross entertainments, etc.

Throughout the succeeding months his condition fluctuated, at times showing improvement and then exhibiting a relapse. On March 8, 1927, he became excited and assaultive, and this condition continued for the balance of the month. On January 19, 1928 he was granted ground parole and handled this privilege well. On October 1, 1928 he was granted indefinite visit to his mother, who had moved to Washington and was living near the hospital. On February 27, 1929, he was discharged as a social recovery.

Third Admission

On June 3, 1929, he was admitted for the third time, coming from the local naval hospital where he had gone at the suggestion of his personal physician. He was quiet and agreeable. It was stated that he had become very restless while waiting to hear the results of a civil service examination; that he would walk the floor, wring his hands, and laugh foolishly. He could give no definite reason why he should be returned to the hospital, but accepted the situation agreeably and said that he was willing to remain under treatment as long as desired, but hoped that it would be only a short time.

During the second month following this admission, he became noisy and disturbed. Attendants reported that he masturbated frequently and shamelessly.

On October 31, 1929 he was reported as having improved considerably; and in December he was again given ground parole, which he handled well until January 1930, when it had to be taken up because of his noisy behavior. He continued to show variable emotions, conducting himself well on the grounds during the day, when he had a special attendant, but being noisy and troublesome at night. On May 31, 1930 he was reported as having been much worse for several weeks; but by October he had again improved sufficiently to have his ground parole restored, and was able to work in the laboratory, where he was very industrious and efficient.

On November 8 he was again permitted to go on indefinite visit to the home of his mother. He was seen at frequent intervals by social service workers during the spring and early summer of 1931, and continued to improve.

On August 21, 1931, he returned to the hospital upon the advice of his relatives, who said that he was somewhat upset and possibly hallucinated. He was well behaved and admitted a history of hallucinations but said that he could not describe them, that they were confused and jumbled.

On January 14, 1932 he was reported as falling to the floor in response to the dictation of "voices" which told him to do this. In February he would not admit hearing voices or having enemies. By December 3, 1932 he was again quiet, and said that he could not remember what he had been excited about or exactly what he had done. Ward notes in March stated that he was reacting to auditory hallucinations. On May 20, 1933 he had a period of acute

excitement during which he yelled, was resistive and unmanageable. Later he said that he had yelled because he was having a baby and declared that he had had eight or nine children during the night.

On May 22, 1933, he was taken ill and died the following morning of chronic valvular heart disease. Permission for an autopsy was refused. The mental diagnosis was dementia præcox.

IV. Discussion

This is one of numerous cases in which early psychiatric attention might have gone far toward delaying, if not averting catastrophe. The patient's father records symptoms at the age of 16 which were clearly indicative of abnormal development and consonant with a typical dementia præcox reaction.

The hereditary picture is not at all clear. Nothing is known about the "insane" cousin mentioned in the medical certificate. A maternal uncle died of heart disease, which was the cause of the patient's own death. Another (paternal?) uncle "took to dope and drinking" after the tragic death of his young daughter. The patient's next younger brother also has heart trouble, is nervous, and "always had difficulty holding a job."

The parents did not get along well together. The patient had been told that they "were almost divorced" at the time of his birth, and that "terrible things happened—some scandal." When he was seven years old, they actually were divorced and he has said that he "remembers vividly one scene which took place" just before they separated, but he would not tell what it was.

A broken home situation thus influenced his childhood development. Apparently there was a fairly strong attachment to both parents, for he says that "it always hurt him that he couldn't be with both of them." He made no comment on either one with respect to their differences and never voiced any criticism of either of them. It is perhaps significant, however, that in connection with his compulsive ideas of cursing other people, it was more often his mother whom he felt impelled to curse than his father (although he did occasionally curse his father, too). During one part of his second admission he showed great irritability toward his mother when she visited him, and she once became afraid that he was going to strike her. It would thus seem that she was the subject of a greater share of unexpressed criticism and resentment

than his father. But she was also the source of his major conflict where incestuous ideas were involved; and part of his periodic antagonism to her was undoubtedly the expression of a defense reaction against these ideas. Once, during his illness, he admitted entertaining death wishes against her:

"I frequently thought of inheriting mother's property—what I would do if I had it. Felt guilty for planning on Mother's death."

That incestuous temptation was at the base of his psychogenic difficulties, it is impossible to deny, for these temptations were not represented by an involved symbolization, such as are found in so many schizophrenic cases, but were consciously present during the patient's disturbed periods. He told the writer that when he was at home his room was separated from his mother's by a curtain and that he "feared that people might suspect us of having relations"; and admits that "during my last sickness, when my mind was awhirl, I did have ideas of having relations with my mother." (See the comment on Dream No. 4.)

B.'s bi-polar parental attitude is further indicated by the fact that once he entertained incestuous thoughts toward his father. And it is known that, when he was 14, he once did have incestuous homosexual relations with his younger brother. The writer has already commented on the unusually pleasurable character of his pedication with the aggressive widow and has suggested its possible connection with the strong (and strongly repressed) impression made upon him at a very early age when he saw his father give his mother an enema. His early asocial tendencies were typical of many homosexuals and there seemed to be no doubt that his true psychic trend was in a homosexual direction, although all the homosexual advances which were made to him met with full or partial resistance because of his inhibitions. One finds mention of only one satisfactory experience with what was presumably normal coitus, and one is led to suspect that, even there, some unknown paraphiliac element, either actual or fantasied, entered into the situation. His preferred form of heterosexual gratification was passive fellatio, but here again inhibition generally prevented both active and passive fellatio with men, although on one occasion he was discovered as the passive partner in fellatio with another patient.

The controlling factor in his psychotic exhibition was the overwhelming sense of guilt which was expressed for the most part in

his delusions concerning what he himself referred to as "telepathy" but which, as already shown, were mainly concerned with his responsibility for all the terrible things which were taking place in the world, as though God were punishing all mankind for *his* sins. This was a sort of Messianic delusion in reverse. Instead of being God incarnate, he was the equivalent of an incarnate devil, spreading plague, pestilence and famine, sin, sickness and death, the only difference being that, rather than glorying in the exercise of such diabolical influence, the patient regarded it as a curse and insisted that he should expiate it with his life. To a considerable extent, these delusional ideas represented an unconscious expression of the patient's sado-masochism, for they appeared to satisfy at one and the same time a strong aggressive tendency and a thirst for suffering. Some of his paraphiliac obsessions served the same purpose. He called an associate "dirty f. c. s." and visualized his mother licking his anus when he defecated. These obsessions were the essence of sadism. In contrast to these he imagined himself eating excreta, pleaded to be hanged, burned at the stake, etc., and even attempted suicide as a means of self-punishment for his sinful thoughts, as well as in an attempt to escape the suffering which these thoughts caused him.

As one reviews his recovery and subsequent relapses, we appear to be concerned with the alternating control and failure of repression. There is no index to his thought content after the conclusion of the interviews which furnished most of the information embodied in this survey, but his subsequent admissions were attended by hallucinatory disturbances and increasingly bizarre behavior indicative of a deteriorating tendency. His final delusional episode, involving ideas of childbirth, may have been largely somatic in character and loosely connected with the cardiac disturbance which, only a day or so thereafter, caused his death.

In an attempt to understand the psychodynamics behind the patient's reactions, it may be observed that for all his sexual precocity and his multiple excursions into different types of paraphiliac behavior, these activities were essentially weak, timid and ineffective —a little of this and a little of that but no more—attaching himself to nothing definite, thus differing strikingly from neurotic and criminal paraphiliacs who elect particular, preferred forms of paraphilias, with energetic excursions into other paraphilias, adjuvants and expedients. He was not unlike a little mouse, moved by

the tempting smell of cheese to touch it, just a lick; then terrified, running back for fear of getting caught. The patient's ramifying mental content—in particular his delusions and hallucinations—preoccupied as it was with all sorts of paraphiliac behavior, was in effect in the nature of strong defense reactions erected by a too robust and over-severe conscience, to prevent him from realizing the variety of paraphiliac drives. Lt. B.'s psychosis thus reveals itself as only a protective barrier that prevented the over-flooding of the personality with socially prohibited sexual behavior. And if it be true that reaction is at least equal to action, then the very malignancy of the psychosis was but an indication of the tremendous strength of the original impulses behind it. The psychosis killed the man; but society was spared the sexual criminal he might have become, had the barriers not been strong enough and had his impulses broken through under the pressure of instinctive drives.

This case is but one of many in which the ambition to succeed has resulted in intellectual development in an individual constitutionally and psychogenically incapable of standing up under the strain imposed by the normal social life of a prevailing culture. B. was able to pass the entrance examinations to the naval academy and to graduate therefrom with a high scholastic standing, but was obviously unfitted constitutionally and temperamentally to make a corresponding social adaptation, with the result that after a few years of active service, he became a total loss. Knowing what we do of his early life, it is obvious that this fact should have been discovered by others long before that naval career was opened to him. Psychiatry which only begins after a personality disintegration has put an individual inside the walls of a mental hospital is of little social value. Cases like this represent a crying need for an earlier and more constructive type of psychotherapy designed to prevent such costly mistakes.

V. Comparison of Lt. B., James A. Q., and Dr. X.

The Role of Physical Factors

There were no physical difficulties in Lt. B.'s history on which he could blame his condition, whereas James A. Q. and Dr. X.* both blamed their breakdowns on army experiences—the first on having been gassed and on a severe fall, while the second blamed

*Ibid.: J. N. M. D., 100:5, 480, November 1944.

his condition on the "shell shock" suffered as the result of an explosion. The actual naval career of Lt. B. is not known, but there is nothing to indicate that he ever participated in battle or had any wartime experience to which he could attach any of his subsequent difficulties.

Homosexual Indications

In all three cases, one finds strong indications of homosexual pressure. In Lt. B.'s case, there is an actual homosexual history. At the age of 14, he practised active pederasty on his nine-year-old brother, and a year later had a similar experience with another boy. Concerning the first, he said, that "there was no satisfaction or pleasure connected with it," and concerning the second, he claimed that he did it just out of curiosity. There were several instances of sexual familiarity with other men, in which they were the aggressors, only one of which culminated in orgasm, with respect to which he says that "it burned" and that he was very disgusted afterwards. His only protracted heterosexual relationship was confined to active pedication, which he says he practised because of his fear of conception, but which actually appears to have involved a compromise formation derived from his homosexual inclinations.

With another woman, B. enjoyed passive fellatio, but his sense of guilt would not allow him to repeat this experience because he thought it was unnatural. At the time of his breakdown, the naval authorities did not attempt a definite diagnosis beyond establishing the conclusion that he was psychotic, but included as part of their opinion the label, "homosexual panic," which indicates that his reactions at that time clearly showed a strong preoccupation with homosexual ideas. During his second admission to St. Elizabeths, he was once discovered in a homosexual relationship with another patient, he being the passive partner in fellatio. The largest classified group of dreams represents those which contain elements suggestive of homosexual interest, although they are without actual homosexual content. (The majority of his dreams are, in fact, without sexual content of any sort, but his associations invariably led to an expression of the regressive fancies with which he was so persistently tormented.)

In the case of James A. Q., there is no homosexual history that the writer is aware of, and all indications lead one to conclude that

there was none. The patient's entire delusional structure, however, appears to be predicated on a strong father fixation. Positively-toned sexual attitudes toward his father are suggested by his sleeping with him most of the time as a boy, loving to feel his muscles, undue curiosity about his father's visits to his mother's bed, and strong unconscious reactions of jealousy connected with these visits. There is a suspicion of considerable voyeuristic activity where his father was concerned, although we have no actual admission of this. His father fixation is reflected in his ancestral delusions, e. g., that he "came from a king snake" (symbolization of paternal strength). His paranoiac delusions of jealousy on the part of others were derived from his homosexual attachment to his father, with its resulting homosexual inclination generally—which took the form of paranoid projection. His grandiose delusions were also traceable to father-identification, which involved the well-known "overestimation of the sexual object"; he "felt he had been led by divine power"; that he "was just as important as Jesus Christ," etc. His periods of "slipping" following which he developed feelings of shame and remorse (but the actual psychic content of which is unknown to us) were undoubtedly associated with regressive fancies connected with his homosexual father-attachment. He complained of the advances of "two homosexual patients," and it was not known whether this represented a fact or a paranoid projection of his own unconscious homosexual interest. The core of his psychosis represents a conflict over his incestuous interest in his father.

The same situation is apparent in the case of Dr. X., except that in his case one suspects the incestuous interest of extending to several members of his family, of both sexes; for the purport of his elaborate delusional system was obviously to make them other than his kin. As pertaining to the homosexual picture, there is the undue significance which the patient attached to his highly developed mammary glands (the over-development of these glands was a physical fact), suggesting ideas of effeminization; his positively-toned emotional reaction toward his father; one of his delusional statements that "they would not ordinarily put a female nucleus into a male body"; his indifferent reaction to his mother's death (which occurred during his hospitalization); his violent reaction to a question regarding homosexual practices: "It is very rare, it is immoral, abortionist, bastardy and cannibalism"; and

his specific denial of his blood relationship to his father and three of his brothers by investing all of them with "invented bodies" (a device created to enable him to surmount the incest barrier). Unfortunately in this case, there is no information with respect to the patient's emotional or sexual relations with any of the members of his family. One is merely left to suspect the existence of numerous episodes within the family circle which involved sexual stimulation, perhaps voyeuristic and/or exhibitionistic incidents, although probably none which were concerned with overt sexual behavior. He was the youngest of nine children, and it may be supposed that the family life afforded considerable opportunity for the development of sexual impressions within the home circle.

Delusional Structure

The main point of departure in delusional structure where James A. Q. and Dr. X. were concerned was its (passive) compensatory or grandiose character. Delusion saved both of them from the unutterable misery which afflicted Lt. B. James A. Q. was "led by divine power" and by being "just as important as Jesus Christ." He also developed fantastic delusions of evolution and descent—he "came from a king snake" and there were "gorillas in between." Even his paranoid delusions do not appear to have caused him any appreciable amount of suffering, for they involved the compensatory thought that they resulted from his superiority, of which others were jealous. Dr. X. had an elaborate and intricate delusional pattern which made him and the other members of his family the creation of the "Watts," who had invested them with "invented bodies" which presumably made them a generally superior set of folks. In both of these cases the grandiose delusions disguised the incestuous factor which, in the case of Lt. B., could only find expression through tormenting thoughts of a frankly recognized paraphiliac character that only increased his feeling of guilt and unworthiness.

The delusional content of the three cases shows considerable variation. Lt. B. was so continually occupied with obsessive paraphiliac fancies that delusion played a comparatively small part in his mental disturbance. Most of it occurred in connection with his initial breakdown and was consistently paranoid, its content resembling superficially that exhibited by James A. Q. He thought there was a combination against him, "fathers of girls spreading

stories" (a paranoid projection of guilt feelings). There were also many ideas of reference; he connected incidents in movies with himself; thought that people knew what he was thinking about, etc. (fear of discovery of his paraphiliac thoughts). His somatic delusions had a little in common with those of Dr. X. He thought he was growing a tail, and concluded that this was a manifestation of "brain evolution," which idea was employed to justify his masturbatory practice, the end sought being an ultimate severance between his brain and his sexual organs (castration complex?). On his second admission, his delusional content was concerned exclusively with ideas of "mental telepathy"—people were reading his mind; their expressions would change rapidly, and he would then have "dirty thoughts." During his last admission he was periodically hallucinated and indulged in bizarre behavior at the dictates of voices. His last delusional episode was somatic in character and was perhaps connected with actual physical disturbance resulting from his developing heart disease. He thought he was giving birth to a baby and said that he had had eight or nine children during the night. This was only two days preceding his sudden death.

In the cases of James A. Q. and Dr. X., there were ancestral delusions designed to disguise incestuous desires. With James A. Q. these were not so clearly stated and by no means so systematized as with Dr. X. They were more or less zoological, being concerned with man's relation to the animal kingdom. The patient "came from a king snake" and there were "gorillas in between," the first idea being associated with the paternal phallus and the second with his childhood impression of his father's unusual strength. There were also compensatory delusions of grandeur connected with his exaggerated idea of his father and his father-identification; he "felt he had been led by divine power" and that he was "just as important as Jesus Christ."

Dr. X. also had some grandiose delusions involving a great number of inventions of a mechanical nature, and also some in the field of medicine. At the time of his hospitalization, however, he had completely discarded these and recognized their absurdity, realizing that he had never invented anything in his life and that all the "inventions" he had mentioned in letters to his sister had actually been in use for many years. But the ancestral delusions persisted and were so complex as to defy comprehensive description. They

involved a mythical race of people called "the Watts," who "have to do with emotional relationship" and who were responsible for the "invented bodies" of himself and the other members of his family, the reason for this idea of "invented bodies" apparently being one which enabled the patient to indulge with impunity in fantasies of incestuous relations which were thus rendered not incestuous because the persons involved were, according to this delusional theory, not members of the patient's family at all. The name "Watt" was identified, even by the patient himself, with the well-known unit of electrical energy, thus connecting electricity with sex in a manner commonly observed in any number of psychotic cases. This elaborate genealogical theory apparently served to save the patient from all guilt reaction, and therefore one finds in his case no paranoid delusions. He was not the victim of any sort of persecution. The "Watts" had so completely taken care of everything that he had no guilt feelings to project upon his environment.

Hallucinations

Hallucination played a negligible role in the case of Lt. B. until his last hospitalization, when it was more in evidence. He fell to the floor at the dictates of "voices" and also experienced imaginary birth pains. Dr. X. was obviously hallucinated, reacting with the silly laughter of the typical hebephrenic. James A. Q. expressed the idea that he had been hallucinated in the past "up until two or three years ago," but there is no mention of hallucinatory episodes during his hospitalization, although it was suspected that his admitted practice of "talking to himself" might be a hallucinatory reaction, as well as his statement that he "feels that he has two minds, an evil mind and a good mind" and that he "has no control over the evil mind," it being suspected that "the evil mind" referred to, represented hallucinatory suggestion.

Psychogenesis

From a psychogenic standpoint, nothing is known of Dr. X. whatever. Such childhood episodes or impressions as may have influenced his development are completely outside our knowledge. The writer has already speculated that because of the "invented body" delusion which removes him from kinship with most of his family there were probably incidents in his life as a child which had an incestuous coloring, but we actually know nothing about these.

In the case of James A. Q., one knows a little more. As a child, he slept with his father, loved to feel his father's muscles, and would pretend to be asleep when his father visited his mother's bed, thereby concealing his interest in and curiosity about these visits. One suspects that similar pretended slumber covered a variety of voyeuristic incidents where his father was concerned, but there is no actual admission of this. His initial jealousy of the intimacy between his parents was later reinforced when his mother's infidelities became known to the neighborhood and other children taunted him with the information that his mother was a "bad woman." The roots of a definite father-fixation are thus shown in his case.

With respect to Lt. B., there is more information than in either of the other two cases. At an early age he saw his father giving his mother an enema, and it seemed to him that she had a penis like a man. There was a traumatic conflict incident to his parents' separation and a vivid memory of a scene which took place between them shortly before this event, the nature of which he would never discuss. During adolescence his development was characterized by many symptoms which boded ill for the future—withdrawal from group activities, periods of absorption when he would stare into space, etc. He was extremely sensitive and highly imaginative; and he reacted with hurt and withdrawal to being branded by his associates as a "sissy." He never developed any spontaneous interest in the opposite sex. There were two known homosexual episodes at the age of 14, and several abortive ones at a later age.

Lt. B.'s only protracted heterosexual relationship was with a woman on whom he practiced pedication. He developed an acute sense of guilt concerning everything related to sex, and his idea of an ideal state was one of complete asceticism. Whatever organic factors may have entered into the development of his psychosis, there was, in his case, a clear picture of continual, psychogenic sexual conflict, and it was this picture which clearly characterized all of his psychotic periods. Frankly incestuous episodes filled his consciousness during the height of his psychosis, and there was probably no form of paraphiliac activity which did not at one time or another torment his imagination. His sense of guilt was constantly active; and his delusions were projections of guilt feelings; whereas Dr. X., by reason of his delusional evasions, appeared to possess no sense of guilt whatever; and the guilt feelings

of James A. Q. were associated with recurring periods of "slipping" which were followed by feelings of shame and remorse. In James A. Q.'s case, delusions appear to have saved him in part from a sense of guilt arising from his incestuous father-fixation.

The psychogenic common denominator in all three cases is the unconscious fear of incest, but its manifestations represent considerable variation. In the case of Lt. B., one finds almost continuous and unrelieved suffering. The patient is obsessed and tormented by paraphiliac fancies which increase his feeling of unworthiness and bring him to the verge of suicide. Even his delusions offer no amelioration of his unhappy state but rather tend to aggravate it. He is the cause of all human disaster and all public calamity. All his waking thoughts are a compulsive preoccupation with filthy ideas, for which he continually reviles himself and on account of which he suffers extreme torment. Only in his dreams is he free of them, for the dreams depict, for the most part, innocuous situations which contain almost no trace of sex; but once he commences to associate, he is sooner or later swept back into the paraphiliac whirlpool of sexual obsession.

Degree of Insight

The amount of insight exhibited by these three patients is perhaps about equal. Lt. B. clearly recognized his deplorable state; in fact, he seemed inclined to exaggerate it; but he had no realization of the fundamental situation which produced it. Nevertheless he improved during each of his first two hospitalizations to the point where he was capable of making some sort of social adjustment, and even attempts at economic adjustments, although the latter, in both instances, appeared to be more than he was equal to and to have been precipitating factors in new attacks. How his third hospitalization would have terminated had it not been for his heart disease, which put a sudden end to his earthly career, one does not know; but there were indications that at that time a certain deterioration had begun to take place, and the outlook was not good.

James A. Q. developed only a limited insight into his difficulties, at which time he appeared to approach, somewhat, the wavering uncertainty of neurosis; but usually there lay behind this a more or less fixed nucleus of delusion which concealed and rendered inaccessible the roots of his mental disturbance. He was discharged for transfer to a Veterans Hospital and track of him was lost.

Dr. X., after two years in the hospital, was discharged to the custody of his sister, and his subsequent history is not known. He developed insight to the extent that he was able to recognize and discard his original grandiose delusions concerning inventions; but this type of delusion was immediately succeeded by a second, involving his complex ideas of genealogy, the control of mankind by the "Watts," their investiture with "invented bodies," etc., which type of delusion apparently remained fixed. Perhaps he really exhibited the least amount of insight of the three patients, for he continued to show a definite splitting which enabled him to talk of himself and his family in a factual manner at one moment, and immediately thereafter discuss them in the light of his delusional system, which made them the "invented bodies" of the "Watts." He also exhibited many of the reactions characteristic of hebephrenia—vacant starings into space, silly laughter as if in response to hallucinations, misidentifications, and other evidences of splitting. But of the three patients, he definitely appears to have suffered the least, for his complex delusional system so completely disguised his sexual preoccupation that the latter did not disturb him, whereas it disturbed James A. Q. periodically and made life a more or less continual hell for Lt. B.

SUMMARY

The case of Lt. B. is one of hebephrenia and provides an opportunity for comparison with two previously studied cases of James A. Q. and Dr. X., for in addition to furnishing material dealing with unconscious mental content, the patient also furnished a number of significant dreams which make possible an even better understanding of the structure of the hebephrenic psychosis.

Hospitalization

The young Lt. B. had stood high in his graduating class at Annapolis and was apparently satisfactorily performing his naval duties when, four years after graduation, he broke down and required hospitalization. By the time he reached the hospital he was found to be preoccupied with a delusional evolutionary theory in which he postulated a connection between the genitalia and the brain, the latter becoming purer as the seminal fluid became whiter. This theory had its origin in the teachings of "the Bible man" who showed him how to "interpret the Bible through one nostril!" He also interpreted adultery to mean sexual relations with people of an inferior stratum of life.

Sex Life

Of his sex life it was learned that although he had no formal sex education and was rather ignorant in many ways, he seems to have been sexually rather precocious, which, as is known, is not unusual in psychoses. When he was seven, he indulged in exhibitionistic games with a little girl and was spanked by his father for this. At eight, he refused to participate in homosexual activities with his brother, but two years later he attempted sex play with a horse and a dog, finding it, however, most uninteresting. At 12 he was disappointed at the sight of a nude woman's breast he spied through the keyhole.

At 12 he developed the fear that when the time came no pubic hair would grow on him, and was greatly relieved when it finally did appear.

At 13, B. was seduced by a YMCA secretary, aged 45, and was disgusted by it. At 14 or 15, he learned masturbation and practised it about once a week, accompanied by fellatio fantasies involving women, occasionally fantasying heterosexual intercourse. Later, to escape masturbation which he felt was repulsive, he resorted to prostitutes with little success or satisfaction. At 14 he had a pederastic experience with his younger brother and at 15 with another boy, both giving him no pleasure or satisfaction. At 15 he had his first heterosexual experience but was so disappointed that he abstained for six years and when he again had intercourse, it was with a widow with whom he had—as a precautionary measure—only pedication, which was also more enjoyable than normal relations. A few months before his hospital admission, he again performed a homosexual act with a man and had an emission. Normal intercourse was marred by premature ejaculation, and he confessed that he received much more gratification from fellatio but desisted because he felt it was "unnatural." Nocturnal emissions occurred only when he dreamed of heterosexual intercourse—not of perversions.

Mental Content

During his hospitalization he was completely preoccupied by obsessive thoughts of homosexuality, paraphiliac fantasies, hallucinations and delusions, incestuous fantasies involving his mother, and all forms of sexual activity in general which were overshadowed by a tremendous and deeply torturing sense of guilt. The delu-

sions were of four types, persecutory, reference, somatic and what he called "mental telepathy." They were really self-condemnatory, making him feel responsible for all the major and minor catastrophies which befell the world. He found himself compulsively cursing everyone, even his parents, and his thoughts were filled with obscene words and pictures. He was obsessed with coprophiliac ideas stemming from a Biblical reference to men eating their own feces. He had incestuous desires toward both parents, and this made him extremely antagonistic toward his mother. He even fantasied her licking his anus during defecation.

Dream Life

In contrast to these nightmarish waking hours, his dream life consisted of ordinary, apparently normal events in which the regressive content was so heavily disguised that it offered no disturbance. A total of 26 dreams was available, most of which were homosexual (heavily disguised) and a few heterosexual, anxiety, paraphiliac and parent dreams. With very few exceptions, the dreams were entirely free of overt sexual situations and were wish-fulfillment in character, serving as a defense against his anti-social tendencies. During the recital of his dreams, several "forgotten episodes" came to light, the most significant of which was a scene of early childhood when he evidently had witnessed his father administering an enema to his mother and thought at the time she had a penis (the phallic mother). This was probably the basis for his great enjoyment of pedication with the widow.

Guilt

It further became apparent that guilt was his real reaction to the separation of his parents because of his fixation on both mother and father. His insistence that the marriage of his girlfriend to another man was responsible for his "nervous breakdown" merely served to emphasize the real cause—his heterosexual maladjustment, his homosexuality and his incestuous cravings. This feeling of guilt was not evident in his normal personality make-up but became exaggerated in his psychotic state. This manifested itself in his second set of delusions—that he was responsible for all public calamities and all natural disasters. His normal feelings of sensitivity and inferiority were also extremely exaggerated, as was his fear, which appeared more like what would usually be termed

anxiety. This fear was his protection against his aggressive impulses.

His strong attachment to mother and father and the great guilt thus carried, resulted in his Messianic delusions in reverse—God was punishing all mankind for *his*, the patient's, sins. These delusions were an unconscious expression of his sense of guilt. His entire hospital course was an alternation of control and failure of repressions. And as the latter process took over, deterioration set in; and his final childbirth delusion appeared to have some connection with the cardiac disturbances which caused his death.

In terms of the psychodynamics involved, the patient's behavior, though precocious and seemingly diversified, was essentially very weak, passive rather than active, and totally ineffective. He had hidden his impulses and interests in paraphilias behind a thick cloak of obsessive preoccupation with them. The psychosis, it appears, was erected against indulgence in socially-prohibited sexual behavior, thus serving a useful social function, albeit in the end killing the patient.

Course of Illness

Since the age of three, B. had frequent periods of depression and was often preoccupied with suicidal ideas, no doubt related to his guilt feelings. However, his promise to his mother prevented him from attempting suicide until his second hospitalization when he tried unsuccessfully to hang himself. During the second hospitalization, the patient was denied ground parole because he still admitted his suicidal ideas, and sometime later he was discovered in the role of the passive partner in fellatio with another patient. Two and a half years later he was finally discharged as a social recovery but four months later was admitted for the third time in a highly disturbed condition, hallucinating actively and masturbating constantly. He had a rather stormy course for four years with only brief periods of remission. He finally asserted one day that he was having a baby and two days later died suddenly from chronic valvular heart disease.

In retrospect, one observes that his schizophrenic behavior was noted by his father when the patient was only 16, so that early therapeutic endeavors might have forestalled the development of his malignant hebephrenic psychosis and prevented his tragic death.

Comparison of the Cases

In comparing Lt. B. with James A. Q. and Dr. X., it is clear that all three felt homosexual pressure—James A. Q. suffered from a father-fixation, Dr. X. extended his incestuous desires to several members of his family irrespective of sex, while Lt. B. was attached to both parents. The grandiose delusions exhibited by James A. Q. and Dr. X. saved them from the miserable existence of Lt. B. Hallucinations were prominent in Dr. X.; no mention was made of them in the case of James A. Q., although he was observed frequently to be talking to himself, while Lt. B. admitted auditory hallucinations only during his second hospitalization.

The insight shown by all three men was approximately equal, and the psychogenic common denominator in all three cases was the unconscious fear of incest; but its manifestations represented considerable variation. The psychogenesis of hebephrenia was best demonstrated in the case of Lt. B., because he was able to give the most information, especially as concerned his dream life.

* * *

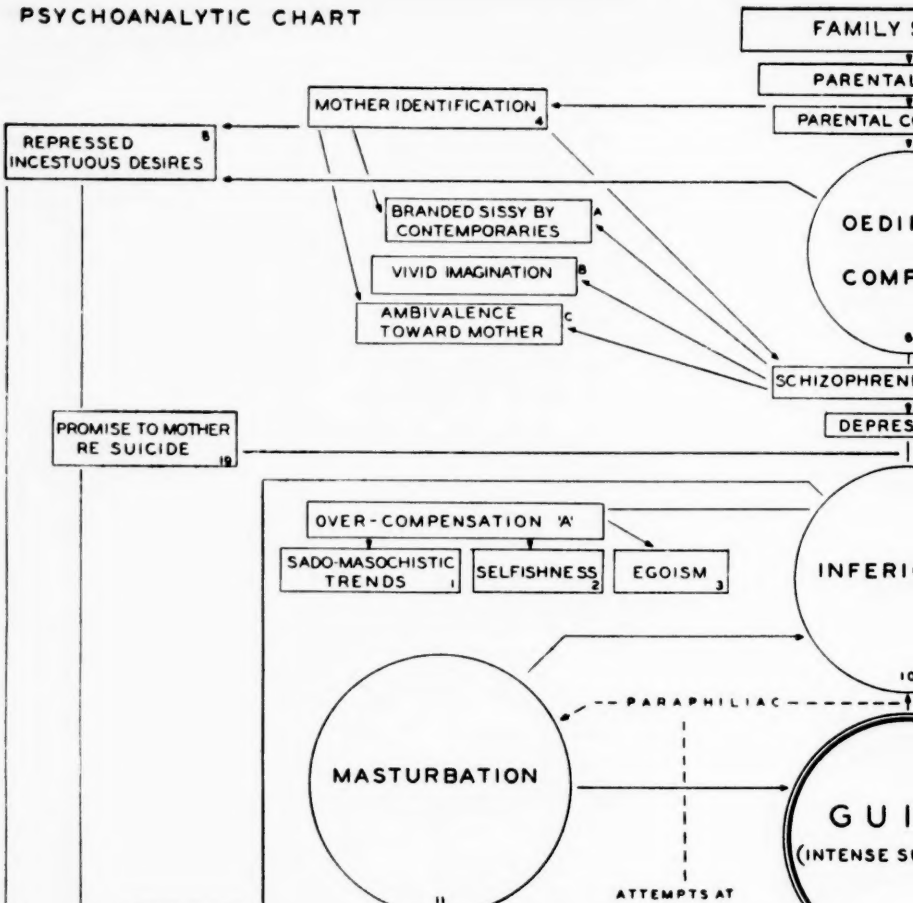
PSYCHOANALYTIC CHART—CASE OF HEBEPHRENIA (LT. B.)

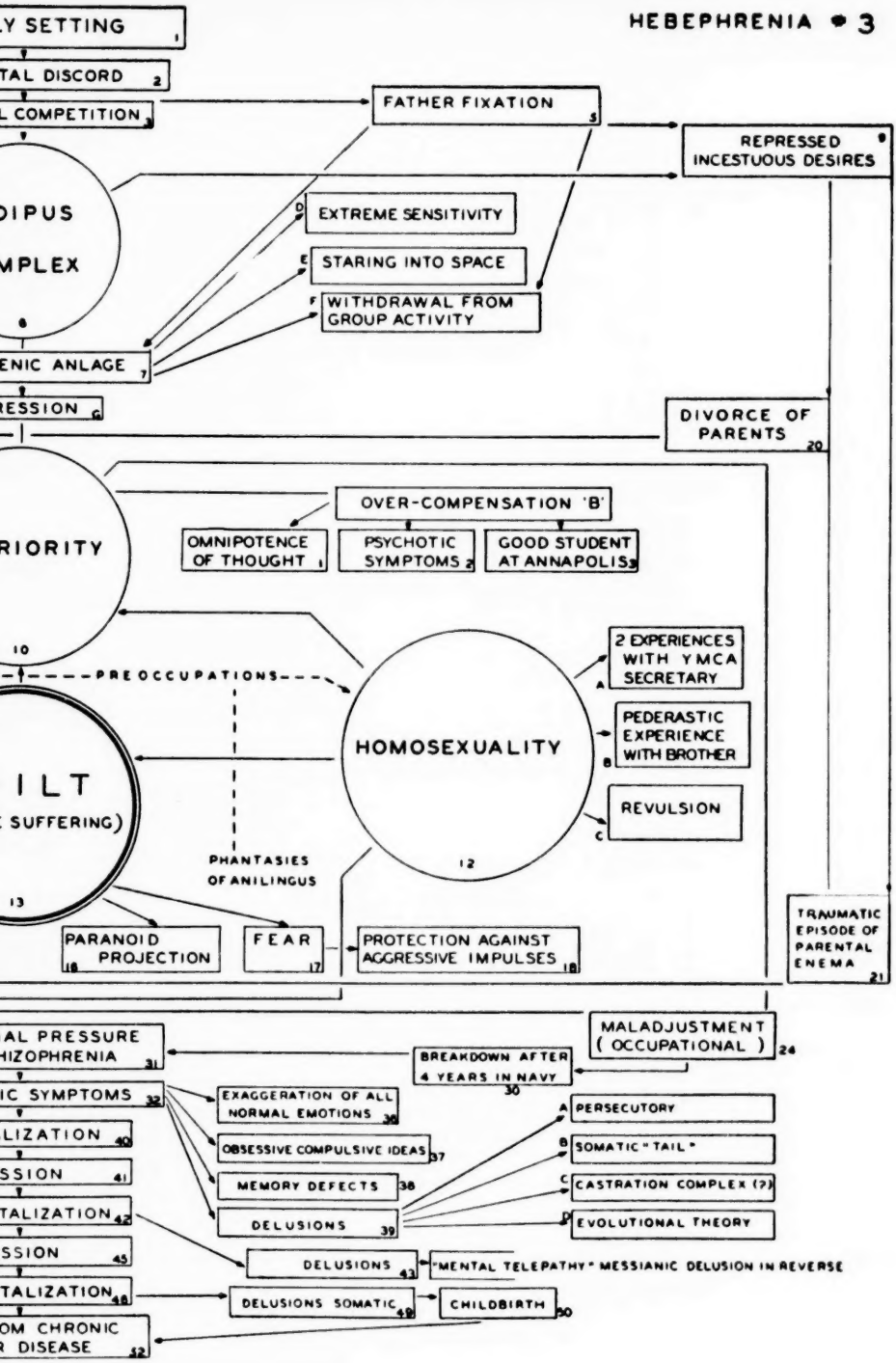
The diagram illustrates the case of a young navy lieutenant, Annapolis graduate (3), who was hospitalized at St. Elizabeths Hospital (40) because of a breakdown after four satisfactory years in the navy (30). He blamed his breakdown (31) on the marriage of his girlfriend (29), although he later admitted that he never "got around to marrying her" himself.

In the hospital, he displayed psychotic symptoms (32) such as sexual preoccupation (33), depression and despondency (34), self-condemnation (35), exaggeration of all normal emotions (36), such as fear, inferiority, guilt, etc., obsessive-compulsive ideas (37), memory defects (38), and delusions (39). The delusions were of four kinds: persecutory (39A); somatic (39B), the idea that he was growing a tail, and that there was a connection between his genitalia and his brain; delusions reflecting the castration complex (39C); and an evolutionary theory (39D), the theory of several generations of Adam.

During Lt. B.'s hospitalization he produced a considerable amount of anamnestic material, including 26 dreams. From this material, a fairly extensive psychogenetic picture of his life could be reconstructed.

PSYCHOANALYTIC CHART




Y SETTING 1
TAL DISCORD 2
L COMPETITION 3
FATHER FIXATION 5
REPRESSED INCESTUOUS DESIRES 9
OIPUS
MPLEX
8
D EXTREME SENSITIVITY
E STARING INTO SPACE
F WITHDRAWAL FROM GROUP ACTIVITY
ENIC ANLAGE 7
RESSION 6
DIVORCE OF PARENTS 20
OVER-COMPENSATION 'B'
OMNIPOTENCE OF THOUGHT 1
PSYCHOTIC SYMPTOMS 2
GOOD STUDENT AT ANNAPOLIS 3
RIORITY
10
PREOCCUPATIONS
HOMOSEXUALITY
12
2 EXPERIENCES WITH YMCA SECRETARY
A
PEDERASTIC EXPERIENCE WITH BROTHER
B
REVULSION
C
ILT
SUFFERING)
13
PHANTASIES OF ANILINGUS
TRAUMATIC EPISODE OF PARENTAL ENEMA 21
PARANOID PROJECTION 16
FEAR 17
PROTECTION AGAINST AGGRESSIVE IMPULSES 18
MALADJUSTMENT (OCCUPATIONAL) 24
AL PRESSURE
HIZOPHRENIA 31
BREAKDOWN AFTER 4 YEARS IN NAVY 30
IC SYMPTOMS 32
EXAGGERATION OF ALL NORMAL EMOTIONS 36
LIZATION 40
OBSESSIVE COMPULSIVE IDEAS 37
SSION 41
MEMORY DEFECTS 38
TALIZATION 42
DELUSIONS 39
A PERSECUTORY
B SOMATIC "TAIL"
C CASTRATION COMPLEX (?)
D EVOLUTIONAL THEORY
SSION 45
DELUSIONS 43
"MENTAL TELEPATHY" MESSIANIC DELUSION IN REVERSE
TALIZATION 48
DELUSIONS SOMATIC 49
CHILDBIRTH 50
OM CHRONIC
R DISEASE 52

The family setting (1) was characterized by parental discord (2); in fact the parents almost separated at the time of his birth, but the patient would not reveal the nature of their disagreement. There was, apparently, competition (3) between the parents for the affection of their children, and out of the Oedipus situation (6) there developed mother-identification (4) and father-fixation (5).

Because of his mother-identification (4), the patient developed many effeminate traits and was branded a sissy by his friends (7A); he had a vivid imagination (7B) and later developed an ambivalent attitude toward his mother (7C). Although he never expressed hostility against his father, he frequently cursed his mother during his illness.

Out of his father-fixation (5), there appeared his extreme sensitivity (7D), his staring into space (7E), and his withdrawal from group activity (7F). During B.'s adolescence, the father was aware of the boy's peculiar behavior and therefore, the schizophrenic *anlage* (7) was already present at that time. As early as the age of three, the boy suffered from periods of depression (7G) which continued to his death.

As long as he could remember, he had had incestuous desires toward both parents (8, 9), which were repressed until the onset of his acute illness. The Oedipus conflict thus produced a great sense of inferiority (10), both physical and mental; and he overcompensated in two directions (10A, 10B).

He developed sado-masochistic traits (10A1), which later became apparent in his delusions. He became selfish (10A2) and egotistic (10A3), characteristics which also manifested themselves in his delusions. On the other hand, he began to feel superior by believing in his omnipotence of thought (10B1), by developing his psychotic symptoms (10B2), and by choosing to go to Annapolis (10B3) where he made excellent grades.

In the most traumatic of all events, when he was seven, his parents were divorced (20), and for this he blamed himself.

His whole sexual life was distorted by his Oedipus conflict (6), and he masturbated (12) with guilt (11) and revulsion (12A). To escape masturbation, he turned to prostitutes, which resulted in more guilt (11) and revulsion (14).

Homosexuality (13) appeared early in his life, as demonstrated by pederastic experiences with his brother (13B) and with the

YMCA secretary (13A). Both cases produced marked revulsion (13C) and further guilt (11).

Guilt (11) dominated his whole life, and produced intense suffering which was greatly exaggerated during his psychosis. It produced fear (17), which also acted as a protection against his aggressive impulses (18). It made him project (15) onto his environment, and made him feel responsible for major public calamities (15), so well illustrated in his Messianic delusions in reverse (43A).

And behind this was the long-forgotten traumatic scene of his childhood, when he accidentally saw his father giving his mother an enema (21) and thought that his mother had a penis.

The patient repressed his heterosexuality (22), which resulted in his severe heterosexual maladjustment (23). When he did not masturbate he had nocturnal emissions (25). His heterosexual contacts were unsatisfactory because of premature ejaculation (26) and guilt feelings (14). He confessed that the only satisfactory relationships with women were either pedication or fellatio (27), but he stopped these because he felt they were unnatural. No woman appealed strongly to him (28) with the exception of his mother, who appeared in many of his masturbatory fantasies.

The one girl who appeared somewhat attractive to him married someone else (29), and although he asserted this precipitated his breakdown, his actions belied this.

His occupational maladjustment (24) took place after four successful years in the navy (30), and he was finally hospitalized (40). His promise to his mother not to commit suicide (19) prevented him from attempting it until his second hospitalization (42).

At that time, his delusions had changed character and were strictly "mental telepathy" (43A), although actually they consisted of his claim that he was responsible for all public calamities (15) and were Messianic delusions in reverse (43A). It was then that he tried to hang himself (44).

He was discharged while in remission (45) on February 27, 1929, but three and one-half months later was readmitted for the third time (46), suffering from hallucinations (47), bizarre, hebephrenic behavior (48), with many somatic delusions (49). There was evidence of deterioration (51), and he continued on a steady downhill

course until his delusions culminated in his assertion that he was giving birth to a baby (50) on May 20, 1933. Two days later, he suddenly died from chronic valvular heart disease (52).

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LIGATION OF THE ANTERIOR CHOROIDAL ARTERY FOR INVOLUNTARY MOVEMENTS---PARKINSONISM

BY IRVING S. COOPER, M. D., PH.D.

It is the purpose of this paper to report experience with a new operation aimed at the relief of involuntary movement disorders. This operation consists of ligation of the anterior choroidal artery. The rationale of this procedure lies in the fact that this blood vessel supplies most of the structures which have been attacked surgically in the attempt to relieve intractable involuntary movements. Among the structures irrigated by this vessel are the globus pallidus, ansa lenticularis, red nucleus, retrolenticular portion of the internal capsule, corpus luysi, substantia nigra, optic tract and cerebral peduncle.

It is beyond the scope of this report to review the literature or describe the neuroanatomy or physiology of involuntary movements. Rather, it is only the purpose to call attention in a preliminary fashion to the early effects which have been noted following ligation of the anterior choroidal artery in cases of parkinsonian tremor. This operation was developed as a result of the unexpected disappearance of unilateral resting tremor in one case following the interruption and subsequent ligation of a vessel considered to be the anterior choroidal artery.

Case Reports

Case 1. W. T., a 36-year-old white man, had suffered from severe parkinsonian tremor associated with most of the other known symptoms of advanced Parkinson's disease for 18 years. This had become progressively more severe from the time of onset, and for 10 years the patient had been virtually disabled. As early as 1943, he had needed assistance to get out of his chair, and was unable to perform such usual simple tasks as feeding himself, or going to the bathroom. He was admitted to Kings County (N. Y.) Hospital in 1945 because he was unable to take care of himself. He stated that he would attempt suicide but was unable to do so. He was admitted to Central Islip (N. Y.) State Hospital in 1949. He was never able to stand or walk from the time of his admission to Central Islip.

Prior to operation this patient demonstrated constant, severe, alternating-type tremor of all four extremities, worse in the upper extremities. Speech was unintelligible. He had not been able to hold a pen or pencil to write for 10 years. He was a full-time nursing problem and had to be fed, bathed, clothed, and completely managed by the nursing staff. His left anterior choroidal artery was ligated through a left frontotemporal craniotomy early in 1953. Subsequent to this operation, although motor power was unimpaired, resting tremor, rigidity, and cogwheelism disappeared completely from the right extremities. The right anterior choroidal artery was subsequently ligated by means of silver clips through a right frontotemporal craniotomy. One week following this operation, the patient could get briskly out of a chair, walk rapidly without any evidence of festination gait, speak clearly, and voluntarily write the surgeon a full page letter by his own hand. There is practically no tremor, at rest, in either of the upper extremities. There is moderate tremor during excitement or emotional duress. Rigidity and cogwheelism are absent from all four extremities. Speech has become intelligible. The patient can feed himself, clothe himself, hold and drink a glass of water without difficulty, and attend to his excretory functions alone and unaided for the first time in more than 10 years. This improvement appears to be progressive to date. However, long-term results must await further observation.

Case 2. P. W., a 38-year-old white man, suffered a known attack of encephalitis at the age of 20. Shortly thereafter, he had the onset of typical postencephalitic parkinsonism. He had progressively more severe tremors, involving both upper extremities, oculogyric crises, and festination gait. Rigidity of all extremities was marked. The tremor became so severe as to require constant nursing care. Therefore, the patient was admitted to Central Islip State Hospital in 1944. His diagnosis at that time was postencephalitic parkinsonism and mental deficiency.

Early in 1953 the right anterior choroidal artery was ligated by means of silver clips through a right frontotemporal craniotomy. Since immediately following the operation, there has been an absence of rigidity and cogwheelism on the left. Resting tremor in the left extremities has been almost completely absent. The tremors return to a moderate degree during excitement. The tremors,

rigidity and cogwheelism of the right extremities have persisted. Motor power of the left extremities has improved as compared with the preoperative state.

Besides these two cases, which are cited very briefly and without detailed description, six additional ligations of the anterior choroidal artery have been performed. The early results obtained in all these cases have paralleled the postoperative findings cited in the foregoing. That is, following ligation of the anterior choroidal artery, there have been noted: marked diminution of contralateral tremor, disappearance of cogwheelism and rigidity from the contralateral extremities, and improved motor power in the contralateral extremities. The writer has not noted any instances of hemiplegia or hemianesthesia. Gross confrontation testing has not revealed visual field defects. Detailed visual field studies are in progress.

For the sake of brevity, many significant details have been omitted from this brief report. It has been the writer's purpose only to point out that surgical occlusion of the anterior choroidal artery can be accomplished safely and with apparently significant clinical and neurophysiologic results.

Summary

Two cases of ligation of the anterior choroidal artery have been reported to illustrate the writer's investigative use of this operation. He has found, following ligation of the anterior choroidal artery, in cases of parkinsonism, a diminution or relief of the typical resting tremor in the contralateral extremities. He has not noted any instances of hemiplegia or hemianesthesia following this operation.

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EDITORIAL COMMENT

BORN UNTO TROUBLE

It seems to be a good idea on occasion, and a timely one on almost any occasion, to question whether all the apparent ills in the world are entirely unmixed evils.

Psychiatrists, like other humans, can look at one side of a fact so intently as to see little of another side. We think pain is a case in point. The physician is dedicated, by a great oath to the healing god, Apollo, to seek the benefit of his patients, in which objective the relief of pain has been comprised from time immemorial. Pain is plainly one of the "deleterious and mischievous" things against which the physician pledges himself in the Oath of Hippocrates; and, although the doctor may make daily use of a patient's pain in diagnosis, his orientation is all toward regarding it as an evil or a sign of evil. The psychiatrist in particular, engaged in endless struggle against mental suffering, may be likely to forget that from other than the medical point of view, pain may have important, or even essential, personal and social functions. We think occasional examination of those functions may have its uses.

Pain is one of those experiences which everybody has, almost nobody likes, and nobody can define satisfactorily. For a noble effort at definition—but one which nevertheless comes short of the goal—we may commend Josef Matfus' short study in the January 1951 issue of this QUARTELY; and one could compile an impressive bibliography of scientific books and articles on the subject. But we know of no truly definitive treatment of the phenomenon and of none that may be considered both reasonably comprehensive and reasonably objective. Pain is too personal and too subjective an experience for direct comparison from individual to individual, or for the sort of direct measurement one employs in reading a temperature, doing a blood chemistry, or determining a person's rate of basal metabolism.

Pain is another of those subjects that one is compelled to discuss without knowing with any great degree of certainty just what is being talked about. Consider the dictionary's difficulties. Webster says, among other things, that pain is a "form of consciousness . . . varying from slight uneasiness to extreme distress or

torture." But "uneasiness" is a state of being "disturbed by pain"; "distress" is the "pain of suffering"; "torture" is extreme pain. "Torture" is also "torment," and "torment" is, besides being "agony," "that which gives pain." And "agony" is "anguish," and both "agony" and "anguish" are "extreme pain." So we might as well hold our hats; here we go again! Or, perhaps, like the Tentmaker, we have already arrived, coming out by that same door where in we went.

Pain is a phenomenon almost perfectly adapted to illustrate the philosophical proposition of solipsism: "that the self knows and can know nothing but its own modifications," or, as Webster adds, the "inaccurately" derived conclusion "that all reality is subjective. In this respect, pain is not unlike psychosis. One of the recognized great in the psychiatric world had a brief psychotic episode in his old age—with hallucinations and delusional ideation—in the course of an organic illness. He was pleased, on recovery, with the additional insight the experience afforded. "Now I know," he wrote to a friend, "how my patients have been feeling all these years." But how can one truly know such a thing? We are inclined to think that man's capacity for various degrees of identification with his fellows is as important for human progress as is any other human attribute; but even he who identifies most fully, he who comes nearest to assuming the feelings and thoughts of another person, is carrying his own emotional, experiential and intellectual equipment into the identification process with him. We take to ourselves another's joy or grief, or fright or rage, on our own terms; or, for all practical purposes, we must assume that we do.

So with pain! One cannot measure subjective (hallucinated) voices accurately in terms of decibels. And the scale of dols, by which we attempt to measure pain intensity as we measure noise intensity in decibels, is based on criteria so subjective that one wonders if reports can ever be really comparable or data reliably standardized. We are not sure whether it was medical school or psychology class that originated the plaintive masculine inquiry to the women who had just agreed that childbirth was the most painful experience in the world: "Pardon me, ladies, but has either of you ever been kicked in the testicles?" All discussion of the castration complex aside, one wonders how even the best modern techniques, devised and administered by the most careful workers,

can ever make accurate comparison possible of the grossly different types of pain occasioned by sex differences—let alone between grossly similar types where the individuals concerned have no sex differences.

A physician notes the case of a patient, a football player with a fractured clavicle, who reported that he had not—neither then nor ever—ever felt "pain." What sensation the man had instead, or whether he denied having any, is not reported. Could the problem be semantic, with whatever sensation the patient did have simply not identified by him with the word "pain"? Or was there a true lack of sensation, in which case, how had the man survived cuts, burns, scalds and infections long enough to reach the football-playing age?

In the present discussion of pain and its personal and social implications, we are using the term in its ill-understood general sense. We are calling "pain" any one of the sensations, physical or mental, that we think the average person would call "pain"; and we are largely concerned with matters that have been generally recognized as painful—though not necessarily in the modern scientific setting—from time immemorial.

The survival value of pain to the individual is one of those facts which ought to be self-evident. Gladys Bevans, who is generally considered an authority on the subject of bringing up children, and who is well-recognized as an exponent of the school of understanding, tolerance and gentleness, remarked in a recent newspaper column that in these days of gas stoves and automobile traffic, painful punishment—when there is no chance to reason—is to be preferred to a child's death by accident. It seems to us that this is a very practical point and one which some of the newer schools of child-rearing have not countered satisfactorily. The value of pain as a life-saver is implicit in such ancient observations as that burnt children shun fire and that people once bitten are twice shy, while it is invoked as a socializing instrument in such admonitions as the warning not to spare the rod lest one spoil the child—a procedure we disagree with emphatically, but one illustrative of an important relationship.

Pain is probably an invariable accompaniment of birth and is a frequent accompaniment of death; physical pain of one kind or another must have been an almost ever-present factor in the life of primitive man; and physical or mental pain may be ever-present

in the lives of unfortunate individuals anywhere in the non-primitive world of today. The unpleasant aspects of pain have probably been as important as any other single factor in teaching man to minimize the physical risks of life and so increase his chances of continuing to live, and to minimize the risks of social life and so increase his chances of continuing and developing social living.

Pain as a social institution in itself was established in the mists of man's remotest antiquity. Pain was a prerequisite to initiation into manhood, and often into womanhood, in the vast majority of "primitive" societies known to the science of ethnology—although one may question here the use of the term primitive, since all of them must have had tens or hundreds of thousands of years of fully human evolution behind them before science made their acquaintance. Circumcision, subincision, ceremonial defloration, the knocking out of teeth, the amputation of fingers, the deliberate deformation of the skull, tattoing, human sacrifice, were all expressions of a human impulse to inflict or suffer pain that must have been universal. If one could find lower mammalian examples —and it is true that the males of most species fight each other for the females, that life for most wild animals must involve much injury, hunger and other suffering, and that many students think elements of cruelty invariably enter into the animal sex act—one could almost postulate a genetic impulse for some of man's most painful practices. Biological or not, we can be certain that pain has been a (perhaps necessary) accompaniment of human socialization from the most ancient times. Man has always experienced, and he cannot today avoid, the traumata of birth and weaning, which, incidentally, he shares with the higher animals.

The existence in remote times—we think—of purposely created pain, with its results of fear, anxiety and other unpleasant human reactions and emotions, has been a major force in socialization and progress. Physical and mental pain have been used to force compliance with social rules and regulations, while many of society's organized efforts have been devoted to the alleviation of such avoidable pain (as from cold, hunger, illness) as has not been purposely employed. The science of medicine and the specialty of psychiatry are dedicated, and always have been so, largely to the relief of pain, psychiatry to relief of that pain which we believe to be the worst of all, the pain of emotional or mental suffering. Almost the whole of the rest of man's science and technology has

been employed directly or indirectly toward the lessening of human pain, by increasing facilities for positive enjoyment of life and by minimizing the risks of life.

But men are, by emotional and intellectual necessity no less than by environmental pressures, risk-takers. If life held no risks, we would have to invent some. And risk-takers cannot avoid all pain. And there is the pain not connected with voluntary risk, the pain of the mental derangements with which psychiatry deals, for example. We employ the operation of pre-frontal lobotomy in certain cases of such pain. It appears to reduce the patient's appreciation of both physical pain and the pain of anxiety. But in considering this result, we must consider also the possibility of the undesirable complications known as post-lobotomy personality changes; and, in attempting to evaluate what we have done, we must note again that we may not be reducing pain itself, but merely appreciation of it. This may be a distinction without appreciable clinical difference; clinically, the relief of pain and the relief of appreciation of it may amount to about the same thing; but the lobotomy sequelae are an uncommonly good illustration of the fact that in undertaking pain relief, it is difficult to be certain of what we are doing.

In the relief of emotional and mental pain, we have found no way to avert all of the suffering caused by such universal traumata as weaning, sibling jealousy and the shattering experience which, misnamed or not, and biological in origin or not, we find it convenient to call the Oedipus complex. Medicine has, in fact, been much less successful generally in relieving mental or emotional pain than in relieving physical discomfort. The narcotics can eliminate or greatly lessen the physical pain of a cancer; but mental specialists have not been notably successful in relieving the mental pain that is born of the anxiety and the fear of death and helplessness caused by cancer. Similarly, we think that those concerned with the new specialty of gerontology are having more initial success in the treatment of the physical aches and pains of old age than in treating the emotional pain which generally accompanies the aging process.

What we are wondering about here, however, is not the relief of pain, but the question if—in preoccupation with relieving and avoiding pain—there has not been a tendency to lose sight of the fact that pain does have certain values, in individual survival and

in social and psychological consequences, and if there has not also been a tendency to lose sight of the fact that there are other time-tested methods of coping with pain than relieving it. We have in mind in particular what has been considered from ancient times the virtue of stoicism, fortitude, the quality the army has long called "guts," the age-old counsel that when pain is unavoidable the thing to do is "grin and bear it." It should be said, plainly, emphatically, and without quibble here, that what we are advocating is, to the best of our knowledge and belief, and taking into full account the unconscious impulses we must share with mankind in general, neither sadism nor masochism. We are emphatically not of any school that considers it virtuous or normal for man to take pleasure in inflicting or undergoing pain, physical or mental; and, in particular, we consider man's proneness to what Bergler calls psychic masochism an affliction calling for all our efforts in treatment and prevention. Rather, what we are trying to say is that man is born unto trouble (as the sparks fly upward), that sometimes the most practical way to meet suffering is to set one's teeth and endure it, and that sometimes this is the best way to meet it, as well as the most practical.

We think most people know all this but are inclined to be neglectful of it. After all, most of us were brought up, among other maxims, on "What can't be cured must be endured"; and we think it might be intelligent to repeat this oftener to ourselves, and oftener to our children. It is probably more "natural" to weep and give way than to withstand silently and boldly. Judging from our physiological reactions, it is at least as "natural" to flee terror as to confront it. It is certainly easier to scream or moan than to bite on the bullet. It is easier to run than to fight, easier to avoid risk than to risk hurt. It is easier to vegetate than to chance an injury in some enterprise. But very often the easy way is not the better way—or in the long run even the more comfortable way. And, fortunately for human progress, it is very often not the human way.

As workers in modern science, as well as ordinarily intelligent observers, we are inclined to think the human race may be entering its dangerous age, and that people are going to get hurt in it. The atomic era opens a new world for our children and our children's children's children; and we can be sure it will not be a safe one in respect to life and limb—at least not for ages. Science is

not being advanced for the timorous; the experimenter will always have to test the theorist's conclusions; and human lives may some day depend on such strange things as whether distance to the Great Nebula of Andromeda has been measured accurately—that is within a few thousand parsecs; or as to whether the penetrating power of this or that death-dealing X-particle has been calculated correctly for this or that protective material within a safety limit of half a dozen micromillimeters. Since we are not prophets, astronomers, nuclear physicists, or even science fictionists, members of all four professions may amuse themselves with these illustrations if they will; we do not pretend to guess the terms or the concepts of the science of the future; but we are completely certain that fingers will be burned in playing with it.

We believe this adds some present urgency to a question that should be timely anyway: Is our attitude toward pain—as implied and expressed in our medico-psychological endeavors—either the most appropriate one under present and foreseeable circumstances, or could it ever be appropriate for mankind at all? The tendency to assume that pain is an evil under all circumstances and the efforts to avoid or alleviate it under nearly all circumstances represent a wide drift from our own pioneer attitude of a generation or so ago, and from the traditional attitudes of the peoples who laid the foundations of western civilization.

We think there is a great deal to be said for our ancestors' viewpoint. Some physical—and perhaps much more mental—pain is the unavoidable lot of man at all places and in all times. We think man should be prepared to endure such unavoidable pain and unavoidable painful experiences with more fortitude than the doctrine of alleviation suggests. We do not suggest the revival of the ordeal for youth reaching manhood, or the revival of other painful initiatory experience, although, besides the superstitious and sadistic elements involved, there were matters of value in some of these practices—since it is well for youth to understand and be prepared for the things youth must actually experience.

To be hurt is not always something that at all costs should be avoided. Grish Chundar, the Bengali, in Kipling's tale, *The Finest Story in the World*, tells the Englishman: "I am afraid to be kicked, but I am not afraid to die, because I know what I know. You are not afraid to be kicked, but you are afraid to die. If you were not, by God! you English would be all over the shop in an

hour, upsetting the balances of power and making commotions." Leaving the question of being afraid to die, which, as Kipling himself would say, is another story, not being afraid to be kicked is the key to adventure, colonization and empire. Our fathers, our grandfathers and the elders among ourselves were brought up on tales of human fortitude and human suffering. The crew of the *Nancy Brig* spent so and so many days at sea in an open boat; they starved, shriveled under the sun, went mad from drinking salt water and urine—but some survived. A pioneer's leg was crushed; he could not get help; he applied a tourniquet himself, filed the back of his hunting knife into a crude saw, cut off the flesh, cut through the bone with his home-made saw, heated the knife in his fire and cauterized the raw flesh when the blade was red hot—and he survived. The Indian sneered, sang, boasted, or was impassive under torture. The pioneer white man emulated him.

We do not decry the splendid efforts made all through the history of our culture to minimize man's chances of being hurt and to minimize the risks of disease, untimely death and crippling injury. In these efforts medicine has played a splendid part. The mere fact of living no longer exposes western man to the risks of the black death or Asiatic cholera, or to serious risks from typhoid, typhus, diphtheria, smallpox or malaria—all former scourges of the earth. Modern sanitation under medical direction has reduced vastly the risks of other disorders; and there are prospects for the conquests of such ills as poliomyelitis, tuberculosis and at least some forms of cancer, though our generation may not live to see all these.

Progress in social organization, too, has lessened the risks civilized man runs from such varied sources as general ignorance and criminal elements. Twenty-five years ago, in fact—and until Hitler demonstrated once more that man's greatest danger is man himself—it looked as if mankind could at least map a way toward the eventual elimination of the risks that could then be identified, including warfare. As technology advanced, the conditions of living were becoming safer.

But as technology has advanced further, no man, or no institution, is now safe. We presume few persons, even under the most favorable conditions, have ever wanted a completely riskless world. If any ever did, we think the chance for it disappeared forever, or maybe only for a few millennia, on July 16, 1945 at Alamogordo in

New Mexico. Man put his hands that day on a force which, if he does not destroy himself with it, he is certainly going to use in attempts to explore the universe in one way or another; and we may be certain that he will either succeed or will continue trying for the allotted span of his species upon the earth. There were already, besides unavoidable risks man must take, avoidable ones he must also take because he is man. There are many more such avoidable risks now; and the unavoidable ones have been multiplied many-fold.

We think we would do well, considering what lies before us, to attempt more in the way of teaching men to accept risks and endure pain with fortitude. We think that, in the entirely proper aim to relieve man from unreasonable fear and anxiety, there may now be failure to emphasize sufficiently the human need for the ancient qualities man must have to face adversity. We think we may need, in a rapidly changing world, a little less emphasis in our mental hygiene programs on security and a little more on the conscious and teachable virtues of stoicism and fortitude. And we say this with full recognition that emotional security on the unconscious level may be a prerequisite to the development of real courage on the conscious level.

It is not impossible that a slight change in outlook might also have benefits more immediate than in the speculative atom-age future. Such a change might help, for instance, if we as a nation go to war again, to distinguish better between cowardice—which we take to be a yielding to conscious fear of the sort which men can be trained to face—and the unconsciously-based neurotic symptoms which properly call for psychiatric, not disciplinary, attention.

We think man needs courage to face the future now, and that our children will need infinitely more of it. Nobody need fear for, or make apologies for, the members of our present generation who have faced a world war that was terrible almost beyond conception, and who faced it with all our ancestors' courage. But we think we need more of their quality; and we think we can breed more of it, by teaching it again as a virtue—as our forefathers did—and resisting those who would decry all heroism as childish exhibitionism.

We don't know where the atomic era is going, but we are well on our way; men are going to take risks because the risks have to be taken, and other risks just because men are men. A lot of us are going to be hurt, and we may as well ready ourselves and our chil-

dren for it. We think whatever is done educationally (in the way of mental hygiene) will have to be planned with great care. The good in fortitude and the evil in cruelty are less easily distinguished than they are readily mixed. The bloody path of cruelty leads back to the earliest annals of man; the urge for cruelty may even be biological. One of the oldest of mankind's social records is a cave-painting, attributed to the Aurignacian period of the Old Stone Age and found in a cavern in northeastern Spain. It may be 20,000 years old or older; and it depicts a ceremony which certainly ended in a bloody bacchanalia of human sacrifice. Sadism, or more likely, masochism, is evidently older than any civilization we can trace. And we think today's careless, ignorant or perverted teacher of stoicism can easily preach brutality instead. Humanly —not psychiatrically—speaking, we all know brutes who can't distinguish between brutality, bullying and fortitude, and we want no such teachers, though some of them are far from being the worst of men.

But in working for greater emotional security for our children, it is easy to over-reach; it is easy to confuse emotional with material security; the world is infested with infantile adults who insist on being babied by their families, by benevolent organizations, or by the state. In any reorientation of teaching there is risk. We think moderate reorientation here is a warranted risk, one as well worth taking as others we and our children will be forced to assume. And we think, even if teaching occasionally goes wrong, that it will be easier to meet occasional increased brutality with increased courage than to meet other foreseeable risks without it. At the onset of an era, man can no longer build for the future on the assumption of an even doubtfully-stable world. Man must, if he is to cope successfully with his multiplied problems, plan instead to meet the unpredictable hazards of unpredictable change with increased bravery to dare, stoicism to endure, fortitude to withstand. We shall never be lost as long as we can carry with us into the future the guiding light that is man's finest inheritance—the courage of his ancestry.

BOOK REVIEWS

Ego Psychology and the Psychoses. By PAUL FEDERN, M. D. Edited with an introduction by Edoardo Weiss, M. D. 375 pages, including index. Cloth. Basic Books. New York. 1953. Price $6.00.

The late Paul Federn was a patriarch of the psychoanalytic school. He was a great scientist and a noble personality. Much of his work was many years in advance of his time, and much more of it has been basic to modern progress in psychoanalytic achievement. Federn was a faithful follower of Freud and a daring and unconventional innovator. At a time when Freud himself believed that the psychoanalysis of psychotics was impossible, Federn pioneered in the analytic treatment of these people. His work in ego psychology was fundamental, and his concept of ego boundaries one of the most fruitful that has been advanced for the investigation of personality.

The present work, *Ego Psychology and the Psychoses*, represents selections from his numerous published papers, collected and edited after the author's death by Edoardo Weiss, a pupil of Federn and a close friend for more than 40 years. The papers collected herein cover briefly the field of ego psychology, a longer discussion of the treatment of psychoses, and two of Federn's important papers on narcissism. Some of the collected material was published previously in this QUARTERLY, the first important scientific writings by him since he came to America in 1938.

This reviewer thinks this work one of the most important contributions to psychiatric literature in many years. Its content ranges from material which the psychiatrist in general will find illuminating theoretically, to notes on technique which should be of vast importance to the practising analyst. Most of the number of practitioners reporting successful psychotherapy with psychotics today owe much in the way of basic concept or of procedures to Federn. *Ego Psychology and the Psychoses*, as a development on Freud's basic concepts, belongs with the works of Freud himself among the indispensable foundations of any adequate psychiatric library.

The History and Development of Neurological Surgery. By ERNEST SACHS, M. D. 158 pages. Cloth. Hoeber. New York. 1952. Price $5.00.

The 36 pages of bibliography constitute the main reason for parting with the money to obtain this book. The presentation is interesting and covers all periods of neurological surgery from the ancient trephinings of the skull to recent developments, but the coverage is on the superficial level. Those interested in having a short handbook will find this a valuable one, but the treatment is far from being adequate for any more than a general introduction to the subject.

Range of Human Capacities. Second edition. By DAVID WECHSLER, Ph.D. vii and 190 pages. Cloth. Williams & Wilkins. Baltimore. 1952. Price $4.00.

In this book, Wechsler presents his thesis that the range of human capacities is exceedingly small, that there are calculable limits to human variability, probably biologically determined, and that these limits have the characteristics of natural constants. Using data for physical traits, physiologic and metabolic functions, and some psychomotor, perceptual and simple intellectual traits and abilities, he has devised what he calls the total range ratio. He defines the total range ratio as the "ratio between the highest and lowest, the least and most efficient individual of a measured population with respect to any measurable trait or ability, where the highest and the lowest are defined as the 2nd and the 999th individual in every thousand, respectively." He has found in the data examined that the ratios between the extremes of ability have strikingly recurrent values which fall mostly within the range 1.2:1 to 2.5:1.

This edition differs from the first edition, published in 1935, in the addition of two chapters, one dealing with the span of life as a human capacity and the other on range in productive operations. The chapter on the effect of age has been expanded. The book is an interesting attempt to discover constants in the field of human capacities. The speculations and procedures used should be of interest to those who find the question of variability in the human organism a provocative one.

Sigmund Freud. By RACHEL BAKER. 172 pages. Cloth. Julian Messner, Inc. New York. 1952. Price $2.75.

This is an enthusiastic, though completely naïve attempt at a biography, written with inadequate knowledge, thus conveying an erroneous impression. The book is outdated, and could have been published around 1900. The simplification of Freud's ideas is carried to the point of caricature. It is regrettable that much, though superficial, effort and good will are wasted.

Weeping Bay. By JOY DAVIDMAN. 257 pages. Cloth. Macmillan. New York. 1950. Price $3.00.

This is a hopelessly depressing book, written with good intentions. The topic is the tragically anachronistic society of the poorest of the poor on the Gaspé peninsula, inhabited by French Canadians. The author dwells on this misery; but as a novel, the book miscarries. It is inadmissible, this reviewer thinks, to substitute, for psychological development in a novel, a dramatized sociological treatise, especially when external circumstances are mostly held responsible.

Diagnostic Electroencephalography. By HANS STRAUSS, M. D., MORTIMER OSTOW, M. D., Med. Sc.D., and LOUIS GREENSTEIN, M. D. xiv and 282 pages with 46 figures and 61 tables. Cloth. Grune & Stratton. New York. 1952. Price $7.75.

The layout of this book is such as to allow easy and rapid reference to particular subjects. The table of contents indicates the logical order of the text. The index is fairly complete. The bibliography consists of 17 closely-packed pages. The illustrations are grouped together for easy comparison of the electro-encephalograms.

It is the opinion of L. M. Davidoff in the foreword that, with present knowledge, clinical application of the electro-encephalogram (EEG) may be restricted to a "certain limited group of neurologic diseases."

In Part I, the authors describe the equipment and its application to get reliable recordings. In the many years of experience at Mt. Sinai Hospital, they have set down more rigid standards, differentiating the abnormal from the normal EEG, so that fewer false-positive reports are made. Thus, the readings become more valuable. Provocative tests and physiological correlations are discussed conservatively.

In Part II, the EEG's of numerous organic and functional diseases are described separately. In Part III, the same conditions are examined from a diagnostic point of view. The records are described, classified, and interpreted physiologically, and finally clinically. Numerous cross-references within the text eliminate considerable repetition.

Because of the authors' conservatism, considerable experience, frank discussion and clear exposition, this book is recommended to those who wish to use the technique and who wish to learn to interpret the electro-encephalogram.

In the Name of Science. By MARTIN GARDNER. 320 pages, including index of names. Cloth. Putnam. New York. 1952. Price $4.00.

This is a primer of "crank" scientific literature. Mr. Gardner herein reviews the field of screwball science from Dowie to Dianetics. He covers in outline form a great deal of pseudo-scientific material.

This book can be recommended as a guide for general reading for anybody, layman or scientist, who is interested in mapping the dangerous territory where unscientific concepts are presented in pseudo-scientific form. The one drawback to an otherwise fascinating and useful volume is that the author may have included too much. This reviewer thinks it regrettable that the author should have included—notwithstanding apologetic explanation—a chapter on Rhine's ESP and PK experiments. His discussion of handwriting analysis and drawing tests is, however unintentionally, definitely misleading, and the listing of such people as Korzybski, Moreno and Reich also seems regrettable.

The Wayward Ones. By SARA HARRIS. 220 pages. Cloth. Crown. New York. 1952. Price $3.00.

The author presents in the form of a novel the day-to-day life of an institution for adolescent delinquent girls as experienced by one girl from the time of her commitment until the completion of her training period. Miss Harris is a former staff member of such a school.

In an attempt to point out the weaknesses and inadequacies of the institutional program, she draws a highly exaggerated picture, painting the institution in such a way that one supposes life is rife with perversion in such a setting.

The author offers no positive formulations or suggestions for improvement, although one would hope that an individual who has had an opportunity for such an invaluable first-hand experience would channelize her criticism toward a positive direction. At the same time, perhaps magnification of the ills and problems of this type of institution will alert competent workers in the field of juvenile delinquency to objective examinations.

Rabelais. By JOHN COWPER POWYS. 424 pages, including index. Cloth. Philosophical Library. New York. 1951. Price $3.75.

A distinguished author and literary critic sets out here to do justice to one of the much-maligned great. Rabelais is a dirty word to many moderns; and many who are better informed still have a distorted view of one of the world's great figures because his best-known translator into our tongue happened to be a man of genius himself, with a strong sense of broad humor of his own and little sense of the obligation to be literal. Powys here discusses the translation difficulty, presents a short history of one of the sixteenth century's most fascinating characters, and adds some of his own translations of bits of Rabelais.

The book closes with an interpretation of Rabelais from a number of different angles in which Powys shows a considerable degree of insight and suggests the existence of material very well worth psychiatric study. The reviewer would recommend this work to everybody interested in the genesis of modern literary expression and of modern culture.

Race and Culture Relations. By PAUL A. F. WALTER, Jr., Ph.D. xi and 482 pages. Cloth. McGraw-Hill. New York. 1952. Price $5.50.

Designed as a text in sociological anthropology, this book studies the races that inhabit the various countries and regions of the world, with particular emphasis upon the influences and cultural relationships of minority groups. The approach is explanatory and objective, and there is little attempt to enter into the dynamics of the problem.

Understanding Your Migraine Headache. By CARO W. LIPPMAN, M. D., and MARGARET LIPPMAN. 150 pages. Cloth. Greenberg, Publishers. New York. 1952. Price $2.50.

"After twenty years of clinical work with migraine I have come to realize that it takes a migrainoid to really understand a migrainoid. Migrainoids seem to talk a language of their own. . . . My fair collaborator knows more about migrainoids than I do. She was, and is, a migrainoid who, through understanding and treatment, has found a way of life. She has achieved happiness and contentment, and I, in turn, have benefited thereby. . . ." Because of these experiences ". . . we offer a record of our exploration together into a strange, bewildering, and often amusing migrainoid world."

From this, it would appear that the Lippmans have a background of experience sufficient to give hope to the person who suffers from migraine, but one wonders if they have not identified too many "migrainoids" (a word coined by the authors) by investigation among lay persons. Too, one wonders if it had not been wiser if the authors had used a more scientific method of investigating the problem of migraine and if the authors, before giving their information to the public, had presented their investigations to doctors who have studied the problem.

Medical literature does not lead one to believe that *real* migraine or hemicrania is such a common illness as the authors would lead one to think. Medical literature agrees that real migraine is difficult to diagnose and to treat, that persons with real migraine have prodromal and/or substitutive (equivalent) symptoms, and that such persons have neurotic or emotionally unstable backgrounds. But are all neuroties "migrainoids"? The authors do not state that every one of the persons they have written about has had a real migraine condition before or along with the symptoms noted. This does not mean that the authors are talking "through their hats." No, indeed, they may be entirely correct. But they have not investigated their ideas properly. They have been too fast in presenting their ideas to the layman.

Chapter one starts off with a list of questions such as, "Do you hate to get up in the morning? . . . Do crowds annoy or tire you? . . . Are you absent-minded? . . . Are you a picture-straightener? . . . (etc.)" Then follows, "Check the above questions. If you answer 'yes' to fifteen or more, it's a pretty sure bet that someone in your family has sick headaches. That makes *you* a migrainoid. A migrainoid is a person who has inherited *the migraine factor*. . . . Twelve million Americans are known to have migraine headaches. For each of these, possibly two others have migraine, although they may not be aware of the fact. That makes around thirty million migrainoids. . . .

"A study of migraine is a study in paradox. The migrainoids are normal people who, because of their chemical inheritance, often *appear* to be abnormal. One may have a 'typical headache'; another may go all his life with no headaches. One may be a fussy, immaculate perfectionist; another will be a 'Sloppy Sue' or 'Dirty Dan'. . . . He may be cheerful and optimistic one hour and depressed and discouraged the next. . . . The migrainoid sees things that are not there, hears sounds where no sound exists—or he may not see anything around him and be impervious to the loudest sounds. In the morning he may feel like death; by nightfall he is bursting with health and vitality. He may sleep while others work and work best while others sleep. He is a puzzle to himself and to everyone around him. . . .

"In summary, then, migraine is not 'just a headache'. Headache is the most commonly recognized symptom, but 'migraine equivalents' are as common as the classic headache. . . ."

In their final chapter, "Treatment," the authors mention vitamins, analgesics, hypnotics and ergotamine derivatives as palliative treatment and as preventive treatment. "It has been found that *alpha-estradiol benzoate in sesame oil* is the most effective form of estrogen to be used in treating women migrainoids. *Testosterone propionate in sesame oil* has proved the most effective androgen for treating male migrainoids."

Psychiatric Aide Education. By Bernard H. Hall, M. D., Mary Gangemi, R. N., V. L. Norris, A. B., Vivienne Hutchens Vail, A. B., P. A., and Gordon Sawatsky, A. B., P. A. xvi and 168 pages. Cloth. Grune & Stratton. New York. 1952. Price $5.75.

This book describes a program of the Menninger Foundation at Topeka State Hospital for the training of psychiatric aides. While there are undoubtedly advantages to the program, which devotes a year exclusively to training, there is the question of fitting trainees into positions commensurate with their abilities, and, perhaps more important, finding positions that will pay a salary to make the training attractive. From the follow-up studies done, those students who have graduated so far have done rather well—but would this hold true of large numbers of graduates?

Since the object of the course is not to train toward charge positions but simply to give training for a position as psychiatric aide, the graduates will be placed in the position of either taking charge positions, for which they are not necessarily prepared or suited, or of working for salaries which they could easily obtain in other fields without training. These comments are not meant to imply any dislike on the part of the reviewer for the program—they merely imply a skepticism as to its practicability.

Psychanalyse et Biologie. By MARIE BONAPARTE. 190 pages. Paper. Presses Universitaires de France. Paris. 1952. Price 400 fr.

Psychanalyse et Anthropologie. By MARIE BONAPARTE. 190 pages. Paper. Presses Universitaires de France. Paris. 1952. Price 400 fr.

Marie Bonaparte has been associated with the French psychoanalytic movement from its early days. As one of Freud's pupils she was asked to write an article about works of the Austrian psychiatrist when he was on his way from Vienna to London in 1938. The article, published in the first book mentioned, shows how the author has engaged herself in the struggles both for the recognition of psychoanalytic theory and for the stabilization of the theory of primary phenomena through the successive modifications that Freud himself has brought to his original ideas.

The books are edited with the purpose of collecting papers written between 1933 and 1948. Some of them are barely related to the fields mentioned, namely, biology and anthropology. "The Legend of the Fathomless Waters," "A Lion Hunter's Dreams," and "Notes on the Analytic Discovery of a Primal Scene" appeared in American journals. Others would gain deserved recognition if translated. This writer would like to mention the paper on Saint Christopher, patron saint of the motorist, published in *Psychanalyse et Biologie* and three published in *Psychanalyse et Anthropoligie*: "The Case of Mrs. Lefebvre," "On the Symbolism of Trophies of the Head," and "On Aggressive Autoeroticism of Tooth and Nail."

Discussing data concerning a theory in its evolution, as psychoanalysis has proved to be over the past 50 years, one needs a continuum in elaboration which is not a purpose of these books. However, one can select passages which seem to represent the ideas of the author.

In the book on psychoanalysis and biology, Marie Bonaparte uses terms in a very broad sense. "Psychological data are, as well as the physiological ones, biological data" (p. 5). There is a center or a nucleus where both disciplines meet. Reaching this level we are confronted with many differences of opinion. The author, mainly through the study of female psychosexual development, has come to conclusions, some of which are as follows:

1. "I believe that there exists an organic unconscious" (p. 164).
2. "The antagonism between the integrated personality and the perpetuation of the species is potentially present at the paleobiological stage" (p. 36).
3. "The origin of anxiety is anterior to and independent of any kind of super-ego." (p. 34).
4. "Hunger is more or less satisfied in our society but not the sexual instinct. This fact makes the latter the psychological instinct par excellence."

5. "The biological reaction to the sexual instinct is more pronounced in the female than in the male" (p. 20).

These few excerpts exemplify the labored development of the young science. They are subjects of controversy. Some of these data have been elucidated since. Others remain in the scope of investigative procedure.

This reviewer finds the book on anthropology of greater interest to the contemporary reader. The author believes in a parallel between ontogenesis and phylogenesis. She agrees with Freud on the ubiquity of the Oedipus complex. She presents material collected by herself and others in an organized form. One feels that basically she differs little in her approach from Róheim's methods. Developmental processes on a phylogenetic basis are divided into three stages: animism, totemism, and science.

Both these publications are provocative and worth reading. They demonstrate the continued interest of the author in what psychoanalysis can contribute to other sciences. There is reflected an awareness of the limitations of psychological understanding of biological phenomena, partly because of an initial, overrated goal given to the young science. One questions the fact that this latter attitude was common to most analysts. "The psychoanalyst . . . is a patient and conscientious scholar who . . . has to recognize the eventual limitations put by nature itself on his own power."

The Psychology of Learning. By JAMES DEESE. 398 pages including index and bibliography. Cloth. McGraw-Hill. New York. 1952. Price $5.50.

In the author's words this is a textbook "broad rather than exhaustive, that attempts to survey all the present-day problems in the psychology of learning." The book is recommended by this reviewer as a good survey of this important area. The author, who is assistant professor of psychology at the John Hopkins University, has written a clear account of the basic concepts of learning theory. He has also dealt with the contributions of learning theory to complex clinical problems such as experimental neurosis, conflict and motivation.

The first part of the book is concerned with the basic problems of reinforcement, extinction, motivation, and punishment. Following this are chapters dealing with examples of multiple-response learning. The third part discusses special topics, such as individual differences, emotion and learning, and the neurophysiology of learning. The author also devotes a chapter to current theoretical problems.

The book strikes a good balance between research findings and their applicability to everyday problems of learning. Recent developments and experiments are well discussed and integrated with the earlier classical experiments. The style of the writing is clear and interesting. An extensive bibliography is furnished.

Limbo. By BERNARD WOLFE. 432 pages. Cloth. Random House. New York. 1952. Price $3.50.

Limbo is a brilliant satire on the post-post-atomic world, around 1990, written with rare psychological insight, skill, dry humor. The satire is on many levels, the most important target being the terminal misuse of psychic masochism. A brain-surgeon during World War III, escapes to an uncharted island, leaving his diary behind him; the diary is written in a disgusted-sardonic mood despairing of humanity. His remarks are taken up by a politically-minded friend who promotes them as new dogma. Thus, masochism becomes state religion; amputeeism—voluntary "amp"—the social standard.

Unfortunately, the science of prosthetics progresses, too; the result is that the new limbs are better equipped for World War IV than the natural ones. The description of the imaginary society is hilariously funny; the satire extends to social, sexual, philosophical problems as well. The satire is also a severe indictment of totalitarian thinking and acting.

Limbo is one of the rare books permitting the reader to have a really good time from the beginning to the end of the narrative. It is somewhat reminiscent of Swift's famous *Modest Proposal*, though in a highly modern version.

Look in Your Mirror. A Study in Human Behavior. By JOHN POTTS, M. D., D. C. L. 201 pages. Cloth. Vantage. New York. 1952. Price $3.00.

Each person, as he grows old, regrets that he is unable to pass on to someone the experience, the knowledge, the ideals of living which he has learned. In a pessimistic mood, he sometimes wonders if his living has been of advantage to society. He wonders if he has made his contribution or paid for the privilege of being born.

It seems that Dr. Potts has felt this way and that he has wanted to inform others of his ideals and suggest to them ways of attaining happiness through self-understanding. He writes in a homely but very pleasing style. He makes no effort to be "scientific," and, for this reason in particular, his book will become popular reading for the average person. It should, therefore, be recommended for public libraries.

The Treatment of Injuries to the Nervous System By DONALD MUNRO, M. D. 284 pages including index. Cloth. Saunders. Philadelphia. 1952. Price $7.50.

When *The Treatment of Injuries to the Nervous System* was reviewed in the January 1953 issue of this QUARTERLY, the price was not mentioned. The publishers now supply the information that it is $7.50. The QUARTERLY's reviewer found the book "an excellent, concise guide to the do's and don't's of treating nervous system injuries of all kinds."

Disorganization, Personal and Social. By HERBERT A. BLOCH. 607 pages. Cloth. Knopf. New York. 1952. Price $5.00.

Evaluation of the diverse methods used in the social sciences and the random, indiscriminate collections of facts which have been achieved compelled the author to attempt an integrated theory which would give a more coherent picture. He attempts to tie together anthropology, psychiatry, psychology, sociology, et. al., at the point at which they all converge—the social individual.

The social individual is studied as he refracts the cultural needs, tendencies and lags. As the hub of the wheel on which cultural movement proceeds, the social individual consists of the vital interrelationships between his inner self and his social milieu. There is postulated a parallel development of personal and social disorganization. These diverge from and mingle with the main stream of basic needs and process changes.

Every effort is made to lay the foundation for an effective objective evaluation of key contemporary social problems of disorganization. The theory developed in the first section of this easy-to-read textbook is applied to the facts and individuals involved in delinquency, sex offenses, drug addiction, mental deficiency, suicide, and other social problems of current concern. The individual's interrelationships with the underlying cultural conflicts and the social discord, both of which are inherent in the social structure, remain always in the foreground.

The Psychology of Religion. By L. W. GREENSTED, D. D. 163 pages. Cloth. Oxford University Press. New York. 1952. Price $3.00.

In this book, Dr. Greensted, who is canon emeritus of Liverpool, England, and a fellow of the British Psychological Society, expresses his views relative to the value of psychological theories in the understanding of religion. He reviews and interprets the various schools of psychology and quotes many persons who have molded the understanding of religious beliefs. However, he believes that there is still a big gap in a clear understanding of what one means by religion; that neither psychology nor theology has answered all the questions. He believes that there is a something in the nature of man which is beyond the understanding which psychology and theology can give; that this nature is modified but is not wholly changed simply through a thorough understanding of theological or psychological theories and facts, for, "As has been made only too plain in the course of history, neither good-will nor sound theology nor faith in God have guarded the priest, any more than a knowledge of physiology and anatomy has guarded the general practitioner in medicine, from the most elementary mistakes in judging and handling his fellow-men. . . ."

The Human Side of Chess. By FRED REINFELD. 302 pages, including index. Cloth. Pellegrini & Cudahy. New York. 1952. Price $3.75.

This book is a collection of brief historical notes on modern chess, with chapters on Anderssen, Morphy, Steinitz, Lasker, Capablanca, Alekhine and Euwe. Fourteen famous games in which they participated are appended.

This book is of interest to all psychiatrists who are chess players; and, perhaps because chess has been called a "screwy game," there seem to be a great many such. The careers which Reinfeld sketches briefly are all of psychiatric interest. The brilliant Morphy was extremely neurotic, if not psychotic in his later days. Steinitz died in a mental institution. Lasker ended his life "in shabby exile." Capablanca's eccentricities were well known. Alekhine's life would repay a full-length psychiatric study.

Reinfeld makes much of the stress which chess imposes on its devotees. The professional chess player, the author seems to think, is under mental stress which may lead to abnormality. He does not seem to consider the contrary possibility that a career as a chess player has a particular appeal for certain types of eccentric, if not neurotic, individuals.

The Russian Mind. By STUART RAMSEY TOMPKINS. 289 pages. Cloth. University of Oklahoma Press. Norman, Okla. 1953. Price $4.00.

The period covered by this book is from the accession of Peter the Great to 1855. There is a very complete coverage of the intellectual movements that affected Russia during this period, and of the governmental policies which regulated the life of the people at that time. The author has used the approach of "social classes" to a great degree, placing emphasis upon the effect on society of a weak middle class. There is no attempt to trace the patterns of Russian family life or in any way to seek for explanations of behavior that cannot be directly traced to broad historical influences. This book will be useful to the student of Russian history, but throws little light on the subject for those interested in the *psychology* of the Russian.

My Island Home. By JAMES NORMAN HALL. x and 373 pages. Cloth. Little, Brown and Company. Boston. 1952. Price $4.00.

James Norman Hall writes an interesting book, and this autobiography proves no exception to the general rule. The statement might also be made, again with this being no exception, that he writes a book designed for light reading only. While there is a great deal of material given about the author's life, practically none of it gives any clue as to his deeper personality make-up. It is unfortunate that Hall died before this book was really completed, as the section dealing with his later life in the South Seas is very sketchy.

Theoretical Models and Personality Theory. David Krech and George S. Klein, editors. 142 pages. Cloth. Duke University Press. Durham, N. C. 1952. Price $2.50.

This symposium is an attempt by workers in psychology and related fields to present their theories of personality with special reference to the construction of these theories and the rules and procedures which the constructors followed. Klein and Krech are concerned with "The Problem of Personality and Its Theory"; Von Bertalanffy with: "Theoretical Models in Biology and Psychology"; Hebb with "The Role of Neurological Ideas in Psychology"; Rapaport with "The Conceptual Model of Psychoanalysis"; Miller with "Comments on Theoretical Models Illustrated by the Development of a Theory of Conflict Behavior"; Eysenck with "The Organization of Personality"; Halsted with "Biological Intelligence"; and Angyal with "A Theoretical Model for Personality Studies."

Presumably the advantage of theory construction is that it enables workers to formulate more meaningful questions about the how, what and why of personality. The contributions are of uneven success in both theory construction and in the formulation of meaningful questions. Perhaps the most provocative paper is by Hebb, who makes a very strong point for "physiologizing" in psychology. The most successful paper, in terms of the goals of this symposium and in terms of the clarity with which it is written, is that by Neal Miller. His excellent discussion of the purpose of theory construction and the procedures involved is made more meaningful by an example of the development and testing of a theory of approach-avoidance conflict behavior.

The Bride. By MARGARET H. FREYDBERG. 216 pages. Cloth. Harper. New York. 1952. Price $2.75.

This is a novel of well-written banalities, centering around the first day of a marriage. The naïve-conventional feelings of the newly-weds and the bride's parents are depicted. Had the book been written 50 years ago, it would have been classified as something new. Published, as it is, in 1952, it is full of accepted rehash, replete with glittering commonplace.

Readings in Marriage and the Family. Judson and Mary Landis, editors. 453 pages. Cloth. Prentice-Hall. New York. 1952. Price $5.65.

Here is a collection of 72 mostly sociological studies written by different authors. The editors define the aim: "This book is designed for use either as a reference source for outside reading, to accompany a textbook in courses in marriage or the family, or as the text or the basic reading for a course, supplemented by lectures and class discussion." It is regrettable that unconscious mechanisms are mostly neglected, although a few timid concessions are occasionally made.

Child Psychotherapy. By S. R. Slavson. xiii and 332 pages. Cloth. Columbia University Press. New York. 1952. Price $4.50.

Dr. Slavson's main emphasis is upon the treatment process of the emotionally disturbed child under 12 years of age. He first discusses the various influences and conditions which make for normal personality development including the basic bio-psychological drives and the wider influences of the environment: the physical, material, economic and cultural aspects. The pathology that may occur from deprivation or interference with basic needs or drives or environmental influences is developed in this broad context.

The formulations are largely based on Freudian concepts. However, the author is quick to point out that Freud's major premises were stated from experience with adult patients and in a frame of reference that did not always account adequately for other than the bio-psychological basis of behavior. Actually, Dr. Slavson is eclectic in his thinking and offers recent experimental studies and hypotheses which are more applicable to neo-Freudian child psychology.

Dr. Slavson gives, with enviable clarity, a description of clinical entities, tracing historically the causal factors of maladjustment. This section is excellent and should contribute much toward an understanding of the dynamics that operate in pathology.

The major portion of the book is devoted to a discussion of the actual dynamics of psychotherapy. Here Dr. Slavson has managed to translate heretofore elusively-described aims into a more understandable technique. He states the specific aims of psychotherapy and the dynamic elements of the process, emphasizing the point that there are a variety of therapies and suggesting appropriate types for each clinical entity that is treatable.

This book goes beyond a recapitulation of theoretical constructs. It is a reflection of the most advanced techniques in the field as they are used in actual clinic practice. The book should have wide appeal to anyone concerned with child development.

How to Overcome Sex Frigidity in Women. By I. Devensky. 36 pages. William-Frederick Press. New York. 1952. Price, paper $1.00; cloth, $2.00.

Under the guise of disseminating modern sexological knowledge, a mass of misinformation is promoted. One could write a whole dissertation on the truly remarkable amount of errors concentrated in these 36 pages. Frigidity is mostly credited to man's faulty technique; a "control technique" for premature ejaculation is recommended consisting of interruption of coitus and—"proper breathing."

Toward a General Theory of Human Judgment. By JUSTUS BUCHLER. 176 pages including index. Cloth. Columbia University Press. New York. 1951. Price $2.75.

Erudite and authoritative though this work may be, it is difficult to comprehend, as many explanations tend to complicate an already complex subject. When the chaff has been threshed from the grain, the theory presented for the development of human judgment is found to be more concise and logical than most, and plausible, if not fully established as sound.

The author's ideas are often tenuous and not altogether new, but they are arranged and presented in an original and refreshingly brief manner, i. e.: "The individual in himself constitutes a community, the reflexive and proceptive community. Logically or genetically, the reflexive community presupposes a social community. The soul converses with itself, as the *Theaetetus* says; but it also articulates itself, wars with itself, consoles itself, and fools itself."

This is not a book to be skimmed, but is interesting and worth while if slowly read and digested.

Psychanalyse de l'Antisemitisme. By RODOLPH LOEWENSTEIN. 150 pages. Paper. Presses Universitaires de France. Paris. 1952. Price 500 fr.

This book is known in this country under the title of *Christians and Jews*. Its review here is warranted to bring the reader's attention to an unusually objective study of the problem of anti-Semitism. Dr. Loewenstein is familiar with its irrationality and cruelty. He was born in Russia, migrated to France, and recently has been made aware of anti-Semitism on this continent. He has been subjected to, and has witnessed, its effects on individual personalities. Represented in individual psychology, more or less effectively repressed, the feeling of anti-Semitism is also a phenomenon of collective life.

Psychoanalysts have devoted their efforts to the understanding of the genesis of the apparently incomprehensible symptoms of mental aberrations. Clinical facts initiate the thinking of the observer and, in an attempt at co-ordination, one builds an artificial frame which, for its validation, needs more objective findings. The author is aware of this mechanism and has thus succeeded in writing what should already be considered a classic on the understanding of anti-Semitism.

"The best known and more fruitful cases are those who exhibit a moderate or latent anti-Semitism when the patient requests treatment for a neurosis of some kind. These patients, devoid of any violent anti-Semitism, suddenly develop such symptomatology during analysis. This psycho-

analytic treatment allows an experimental study on anti-Semitism at its beginning'' (p. 17). Two conflicts, important in all neuroses, but especially related to the apparition of anti-Semitism, are ambivalence and the Oedipal situation.

From these findings, through the study of the economical, political, and religious factors influencing the evolution of the problem through the centuries, the author concludes that Christians and Jews form a cultural pair. The understanding of anti-Semitism must result from the study of the interrelations between these two groups. This could be viewed as an interdependence with the elaborate reactions to it. The symptom is said to appear when the reactions of one toward the other group gain a sufficient intensity or tend to generalization.

These few remarks cannot do justice to the book. The author has himself given limitations to a full understanding of the problem, as more data are needed. His apparent disbelief in a parallel between ontogenesis and phylogenesis prevents—to a certain extent—more speculations. ''It is impossible to eradicate from a civilization the traditional and fundamental elements that historically are the roots of modern anti-Semitism. But it will not be always impossible, we hope, to restrain these potentialities from becoming a real and violent collective anti-Semitism'' (p. 141).

The reviewer hopes that every reader of this Quarterly will consult Dr. Loewenstein's book.

Changing the Attitude of Christian Toward Jew. By HENRY ENOCH KAGAN. xiii and 155 pages. Cloth. Columbia University Press. New York. 1952. Price $2.75.

The author, a rabbi, has acted upon the assumption that the basic reason for anti-Semitic reactions among Christians is religious, rather than feeling against an ''outside'' group. This, he feels, accounts for the *specific* dislike of the Jews, while, at the same time, the possibility of other reasons being mixed in is not discounted. An experiment was conducted where groups of 'teen-agers were first tested regarding the degree of their anti-Jewish attitudes and then given lectures—these lectures being followed by another test. It was found that a lecture on the Book of Psalms and its relation to Jewish culture produced no appreciable change in attitudes. A lecture of this type followed by a personal interview with the rabbi had much more effect. Best results, however, were obtained by a ''direct group method'' in which the problem of anti-Semitism was brought out directly in the classroom. This allowed an exchange of ideas and at times an emotional catharsis.

The validity of the testing in this book may be questioned by some, as there is some doubt concerning the relationship of answers to basic emotions. There was a follow-up study done, however, which supported the results of the original scores.

The Wrong Set. By ANGUS WILSON. 239 pages. Cloth. Morrow. New York. 1950. Price $3.00.

These short stories seem to accentuate the aloneness of individuals—where one individual is misplaced in the setting he occupies. The atmosphere can be almost macabre at times. While dealing rather deeply with the personalities of his characters, the author does not give the impression that he is actually studying them—there is a certain distance and objectivity about the way the stories are handled. This reviewer liked these stories, while at the same time not believing that they are the best that the author is capable of.

Witches Three. By FRITZ LEIBER, JAMES BLISH, and FLETCHER PRATT. 423 pages. Cloth. Twayne. New York. 1952. Price $3.95.

The one outstanding feature of this book is the introduction, written by John Ciardi. In this, he analyzes the differing concepts of the witch, relating these concepts to our inner needs and drives. The three stories are fairly authentic as to witchcraft lore, but only one of them, "Conjure Wife," by Fritz Leiber, is a first-class piece of writing—the other two being little above the level of the pulp magazines.

Specific Dyslexia. By BERTIL HALLGREN. (Acta Psychiatrica et Neurologica, Supplementum 65). 287 pages. Paper. Ejnar Munksgaard. Copenhagen. 1950. Price not stated.

This is an exhaustive study of an important educational and intellectual disability, known as "congenital word-blindness." An incomplete definition of this condition would be that it is manifested by poor proficiency in reading and writing in which there is a discrepancy between the low level of attainment here and a higher level in other school subjects, and between the level of attainment and general intelligence.

The author has surveyed the literature (he gives more than 12 pages of references) and he presents a statistical study based on a group of Swedish school children. He concludes that specific dyslexia is relatively common and is probably inherited as a "monohybrid autosomal dominant." His study should be of interest to all concerned with the possible role of inheritance factors as reflected in specific educational disabilities.

The I. R. A. Coventry Explosion of 1939. Letitia Fairfield, editor. 284 pages, including appendix. William Hodge and Company, Ltd. London, (British Book Centre. New York). 1953. Price $3.25.

This book chronicles the trial of the participants in an act which climaxed three-quarters of a century of fanatical patriotism—the bombing at Coventry in 1939 by members of the Irish Republican Army.

This is a clear report of the trial of the five prisoners who were apprehended, and of the conviction of two of them. It is, of course, important psychological as well as historical source material.

Patterns of Marriage. By ELIOT SLATER and MOYA WOODSIDE. 299 pages. Cloth. Cassell & Co. London. 1951. Price 17/6 net.

This is a well-meaning and exceeding naïve study of marriage relationship in the urban working classes in England, written by a psychiatrist and a research psychiatric social worker. Two hundred married couples were interviewed in a London hospital during the period of 1943-46. "Half of them had been admitted to wards for neurosis, half to medical and surgical wards. The latter group can be regarded as psychiatrically normal . . ." Thus, starting with a methodological error (Why should the average patient admitted to a medical or surgical ward be free of neurosis?), the authors compare the allegedly healthy with the neurotics, and arrive at conclusions like these: "About one-third of all women said they experienced orgasm always, and another fifth often or enough; one in four said infrequently or insufficiently, and one in 10 had probably never experienced it at all."

Since the typical figures of other investigators range from 90 per cent frigidity, the authors reverse the ratio to 10 per cent. This miracle is simply explained: "There is a significant difference between the women in the Neurotic and the Control groups; the wives of the Neurotics tended on the whole towards the extremes—more of them had a full experience but 15%, as against 5% in the Control group, never experienced orgasm. These figures are not, perhaps, extremely reliable. It was difficult to word the appropriate question, and doubtful sometimes how far there was sufficient self-knowledge of the physiological event. Many who said 'yes' sounded unconvincing, but had to be given the benefit of the doubt [pp.168-9]."

"It was difficult to word the appropriate question"—that means, the difference between vaginal and clitoridian orgasm was not even known to the investigators. Women who "sounded unconvincing . . . had to be given the benefit of the doubt"—that means the conscious or unconscious prevarications of these women were taken at face value.

How poorly the answers of the men were scrutinized is best visible from the fact that not even one of the 200 had been suffering from impotence. "We have no case in the present series [p. 237]." The potency disturbance most frequently encountered in practice—premature ejaculation—is not even mentiond in the index.

Trends in Psycho-Analysis. By MARJORIE BRIERLEY. 293 pages. Cloth. Hogarth Press. London. 1951. Price 21 s.

This book is a collection of papers of the British psychoanalyst, published from 1934 to 1947. The book is of mild interest only to those well acquainted with Melanie Klein's theories; the author bases her whole approach on Kleinianism.

Evolution and Human Destiny. By FRED KOHLER. 118 pages. Cloth. Philosophical Library. New York. 1952. Price $2.75.

This is a biochemical-philosophical speculative study, embedded in thermodynamic hypotheses. The author is obsessed with the idea of extropy, under which term he understands the tendency to orderliness, as opposed to entropy, i. e., randomness; even art is subsumed: "Art arose out of man's need to create order in his environment; art is therefore an expression of this need." Despite predicted greater and greater "complexification," neither present-day homo sapiens, nor his alleged successor, member of the "supersocietal organism," is conceded an unconscious. The way to achieve the next step of evolution is thus described:

"Progress toward the culturing of human genetic material outside of the human body and success in fertilizing such cultures and raising human embryos, will make it possible to utilize only the germ cells of a few selected individuals to perpetuate the entire human species. Once this is achieved, the logical necessity of the needs of the integrating organism, will probably force society to adopt this method, despite of the social and moral barriers which at the present would seem nearly unsurmountable. The result of such a societal reproductive system will again greatly increase the rate of societal integration and must within a few generations after its general adoption completely transform the nature of mankind." (pp. 110-111.)

As usual, when a hypothesis runs wild, minor considerations, as human happiness, unconscious needs, etc., are gratuitously overlooked.

The Inmates. By JOHN COWPER POWYS. xi and 318 pages. Cloth. Philosophical Library. New York. 1952. Price $4.50.

This by no means can be taken as a serious novel of life in a small private mental institution. It is difficult to judge whether it is meant as an allegory or as a fantasy, but the distinction is of no great importance. The characterizations are interesting, and at times amusing—amusing in the sense of striking close to home. There are sections of absorbing writing and excellent prose, but, to this reviewer, this does not make the book a good novel. The sense of unity, so necessary to the novel form, is lacking.

The Letters of Hart Crane. Edited by Brom Weber. xvi and 426 pages. Cloth. Hermitage. New York. 1952. Price $5.00.

These letters will prove invaluable to anyone writing a psychological biography of Hart Crane, but in themselves do not constitute a study. They are revealing, as Crane was exceedingly frank in his writing, but there has been no attempt to provide any great amount of background material. These letters, as they stand, are chiefly useful to a student of the literary movement of the 20's.

Tuberculosis. By SAUL SOLOMON, M. D. x and 310 pages. Cloth. Coward-McCann. New York. 1952. Price $3.50.

The usefulness of these "Health Series" books, if this member of the series can be taken as a general indication, will not be confined to the general reader for whom they are designed. Anyone in the fields allied to medicine, even nurses, will find this book valuable, for, while the treatment does not go into the technicalities of the subject, the coverage is very complete.

The newest medical and surgical procedures dealing with tuberculosis are taken up, and an intelligent approach is used to the public health aspects of the problem. The section dealing with the emotional aspects of the disease is rather skimpy, with the emphasis here being placed upon the differences between the impact of tuberculosis upon different individuals, it being held that the reaction upon the individual is a stress reaction, not a specific reaction to one disease.

The Conformist. By ALBERTO MORAVIA. 376 pages. Cloth. Farrar, Straus and Young. New York. 1951. Price $3.50.

The novels of the recent Italian writers have tended to be highly "realistic" and more often than not morbid in character. Moravia is no exception to this. This is a trend that is not objected to by this reviewer, except when this "case study" type of approach works to the detriment of the book as a novel—as happens in *The Conformist*. The subject of this novel is a Fascist official who is influenced in everything he does by a strong desire to conform—to be a "usual" person and follow the crowd. He submerges his own individuality to the general pattern. An early traumatic homosexual experience is brought out. The realization by the *conscious* mind of these thoughts strains credulity, as Moravia gives his "hero" almost complete insight into the unconscious forces that guide him. This book is not up to the standards of some of the author's earlier work.

Thinking. By GEORGE HUMPHREY. 331 pages. Cloth. New York. 1952. Price $4.50.

"In general," the author states, "the book is intended to give a critical treatment of experimental work that has already been done." It presents theory as it has developed out of experiments and reviews experimentation in the hope that more may be done.

The author has presented a systematic analysis of experimental work on the "thought processes," including chapters on association; on the work of the Wurzburg group; the mechanism of thinking; the work of Selz; the Gestalt theory of thought; thought and motor reactions; language and thought; generalizations; and an excellent chapter dealing with summaries and conclusions.

This text is a wealth of information for the philosopher and psychologist.

The Devils of Loudun. By ALDOUS HUXLEY. 340 pages. Cloth. Harper. New York. 1952. Price $4.00.

It is difficult in this book to tell exactly where objective history leaves off and the author's own ideas begin. As far as this reviewer could determine the basic facts presented are historically accurate, but it was manifestly impossible to check any great number of the references used.

Urbain Grandier, when vicar of Loudun, was accused of bewitching 17 Ursuline nuns, and, after a trial where there was little attempt at justice, was burned at the stake. The author takes the view that Grandier was innocent of the charges, and that there was no true "devil possession" in the case. He ascribes the actions of the nuns to mass hysteria brought about, in part, by sexual frustration. While making these statements, Huxley in no way shows himself to be anti-religious, and in part the book becomes almost a philosophical treatise. The conclusions drawn are psychologically sound—though there might be skepticism regarding some of the historical assumptions.

The Moral Theory of Behavior. A New Answer to the Enigma of Mental Illness. By FRANK R. BARTA, M. D. 27 pages. Fabrikoid. Thomas. Springfild, Ill. 1952. Price $2.00.

It is unfortunate that psychiatrists cannot get together and decide on a correct explanation of the cause and effect of mental illness. There are almost as many theories as there are psychiatrists (or psychologists, for that matter). Dr. Barta's view is derived from many theories. He has built up his own combination of ideas which, for him, explains the dynamics of mental-problem development. He tells the reader that he is successful in his therapy, but he does not disclose his method of treatment. Further, he does not develop, too well, his ideas of a "moral theory of behavior."

However, the booklet contains several interesting figures based upon his classification and his dynamics of mental illness according to four groups of personalities: those who expect too much of others; those who expect too little of others; those who expect too much of themselves; and those who expect too little of themselves.

Dr. Barta's ideas have merit but he does not explain them clearly.

Tara's Healing. By JANICE HOLT GILES. 253 pages. Westminster Press. Philadelphia. 1951. Price $3.00.

Tara's Healing is a naïvely described emotional rescue of a neurotic physician through loving contact with simple farmers in Kentucky. Mildly interesting is a side-show: A religious sect is described, and their preacher depicted. The conversion of this preacher, his sincerity and truthfulness, are more true to life than the nebulous official hero of the book.

The Postural Development of Infant Chimpanzees. By AUSTIN H. RIESEN and ELAINE F. KINDER. 204 pages, including index. Cloth. Yale University Press. New Haven. 1952. Price $5.00.

Professor Riesen and Dr. Kinder have engaged in a basic psychological study of the postural development of the infant chimpanzee with comparative data on the human infant, and with discussion of development in reference to the monkey as well as to ape and man.

The subjects of the present study were separated from their mothers at the Yerkes Laboratories of Primate Biology and isolated in an experimental nursery where their development was studied under controlled conditions. The conditions of rearing are stated precisely. The examination material is described in detail and there are notes on the comparison of these nursery chimpanzees with chimpanzees raised in human families.

The book is far too technical for general use, but promises to be a basic book for the psychological study of infancy.

The Snow Was Black. By GEORGES SIMENON. Translated from the French by Louise Verèse. 246 pages. Cloth. Prentice-Hall. New York. 1950. Price $2.75.

Monsieur Simenon, the Belgium-born novelist who now makes his home in California, has become known for what his publishers call "psychological" novels, several of which have already been successfully made into movies. By professionals and semi-professionals his novels will more adequately be described as mystery novels of a deeply stirring kind.

The Snow Was Black is a somber description of a young man's egotism and his almost unbelievable degradation, which leaves out no realistic detail, a matter we are used to with regard to Mr. Simenon's novels. Frank, whose life we follow through black market activities and the brothel run by his mother, finally kills an aged benefactress of his childhood. He betrays the girl who loves him sincerely. Destiny in the end catches up with him.

Personality and Sex Conflicts. By H. H. HUSTED. 265 pages. Cloth. McBride. New York. 1952. Price $3.95.

This is a naïve-popular sermonoid with good intentions and rather confused execution. The author takes a dim view of the postwar generation ("New Barbarians") and recommends teaching the Golden Rule.

It's Different for a Woman. By MARY JANE WARD. 246 pages. Cloth. Random House. New York. 1952. Price $3.00.

The author of *The Snake Pit* presents a weak and mild satire of Suburbia. The switch from attack to mild satire does not come off; the book is not exactly boring, but is insignificant.

The Boy Came Back. By CHARLES H. KNICKERBOCKER. 249 pages. Cloth. A. A. Wyn, Inc. New York. 1951. Price $2.75.

The psychology of this book can be summed up with the observation that half-knowledge is dangerous. The author seems to assume that every person is a mixture of *perverse* masochistic-sadistic traits and defenses. He confuses the universality of *psychic* masochism with *perversion* masochism, and builds his *dramatis personae* on this misunderstanding. As he has started with an erroneous assumption, the resultant errors are unavoidable. On the surface, he describes the return of a psychopathic young soldier to his little Maine home town; the suspicion of the conservative inhabitants; and their reactions to the boy's wife, an ex-prostitute from Chicago. Behind this, the author depicts, rather maliciously, the neuroses of the country doctor, the country lawyer, and the country editor. Were the author not confused on basic psychiatric topics, he would be a man to watch for future literary achievements; sometimes he manages to build a scene of real value.

Age Is No Barrier. 1952 Report of the New York State Joint Legislative Committee on Problems of the Aging. 171 pages, including index. Paper. Free, upon request to Hon. Thomas C. Desmond, 94 Broadway, Newburgh, N. Y.

This report includes a survey of the general and—as applied to New York State—particular situation brought about by our aging population. It covers psychological as well as physical problems, social as well as economic. There are chapters on the re-designing of jobs for older persons and the rehabilitation of the physically handicapped older person. Dr. Ernest M. Gruenberg of the State Mental Health Commission contributes a discussion which relates the problem of mental disorder to the problem of aging.

The report is handsomely printed and is well indexed. It should be useful to many individuals, as well as to social and community agencies. Although it does not seem to have been intended for that specific purpose, it is a fine contribution to mental hygiene.

Insanity Laws. By WILLIAM R. DITTMAR. 96 pages. Paper. Oceana. New York. 1952. Price $1.00.

This is a very brief coverage of the insanity laws of the 48 states. The information provided will prove helpful in supplying general information on the subject, but covers no more than the main points. The psychiatric definitions given are much too brief and in certain cases are inaccurate.

Head Against the Wall. By HERVÉ BAZIN. 255 pages. Cloth. Prentice-Hall. New York. 1952. Price $3.95.

When an author has had some success in writing of mental conflicts there seems to be a strong urge to carry this one step further and bring in actual psychiatric background. This, of course, requires far more specialized knowledge. Bazin's first novel, *Viper in the Fist,* was a well worked out study of a neurotic woman—this later effort falls short of the standards set in the first work. Lack of knowledge of the basic facts of psychiatry is shown—both as regards mental processes and treatments. For example: Insulin therapy, shock therapy, and prefrontal lobotomy are all mentioned as being used before they were actually put into practice. The theme—the man doomed to spend his life in mental institutions because of personality weakness rather than any true mental disease, with the usual sidelights of sadistic institution directors, etc.—is not new, and the handling of it is not one to make the book in any way exceptional.

The Nature of Nondirective Group Psychotherapy. An Experimental Investigation. By LEON GORLOW, Ph.D., ERASMUS L. HOCH, Ph.D., and EARL F. TELSCHOW, Ed. D. viii and 143 pages. Cloth. Bureau of Publications, Teachers College, Columbia University. New York. 1952. Price $3.25.

This book should be of particular interest to those concerned with the research possibilities of group psychotherapy. Gorlow, Hoch and Telschow have examined the process of nondirective group psychotherapy from three points of view: (1) an analysis of the leader's behavior and its correlates; (2) the behavior of members as therapists for one another; and (3) the nature of the group process in terms of certain specific variables. The investigators developed a method for the quantification of the transcribed therapy protocols. They clinically evaluated the initial personal adjustment of the members and made estimates as to the least and most benefited members of the group. They related gain to behavior in group sessions. The Rorschach, an incomplete sentence test, and a self-rating check list, administered pre- and post-therapy, were used to provide independent measures of the subjects' initial personal adjustment, etc.

In view of the small number of subjects (117 subjects divided into three groups) and the reliance primarily upon verbal data, the authors regard their findings, not as definitive, but as suggestive of hypotheses for future research. There is a bibliography of 101 titles. The five appendices include the definitions and examples of categories of analysis, the incomplete sentence test, self-rating check list, a group analysis sheet, and group leader feelings toward the members.

Psychological Studies of Human Development. Raymond G. Kuhlen and George G. Thompson, editors. 521 pages. Paper. Appleton-Century-Crofts. New York. 1952. Price $3.50.

The editors, in the foreword of this text, state the purpose and methodology clearly and concisely: "This book is concerned with the psychological aspects of human growth and development, with those psychological changes that occur with increasing age and with the many conditions that influence the course of human development and behavior. . . . This book is not a systematic integration of the literature on developmental psychology. Rather it is a series of seventy-one papers, mainly research reports, adapted and abridged from scientic journals."

The 71 papers are divided into 13 broad areas of psychological endeavor. The first nine are under the collective title "Physical Factors in Psychological Development." There are five in each of the following sections: "Processes of Learning and Adjustment," "Psychological Growth Under Different Social Cultural Conditions," "Intellectual Changes with Age," "Intelligence and Psychological Adjustment," "Patterns of Language-Conceptual Growth," "Interest Patterns and Their Implications," "Social Development: Interpersonal Relations," "Adjustment in School," "Vocational Orientation and Adjustment," and "Some Factors in Personal and Emotional Adjustment." "Growth of Social Values and Attitudes" and "Home Family Relations" each have six articles.

These papers naturally vary in significance and reliability as well as in interest to varying readers. However, as a group, they represent some of the better studies in the areas covered. Rather prominent workers in the field, such as Louis M. Terman, Arnold Gesell, H. E. Garrett, Kurt Lewin and many others have papers included in this book of readings. The abridgements have not been detrimental in those that the reviewer has been able to compare with the originals. This text should prove to be a most valuable source book on current research and psychology, and should be useful to both the beginning student and the esoteric follower of the field.

The reviewer considers it a valuable addition to his library and his only lament is that it is not of a more durable binding.

In the House of the King. By Louis Zara. 306 pages. Cloth. Crown. New York. 1952. Price $3.00.

In this historical novel the author portrays Philip II of Spain as being perpetually haunted by intense guilt feelings due to an unresolved Oedipus complex; and, by means of dream sequences, he keeps this idea before the reader. Philip is held to be a far nicer and less unyielding person than the histories portray. Both as regards the psychiatric overtones and the novel as a novel, the verdict is a polite yawn—not bad enough to be really condemned and not good enough to be praised.

A Behavior System. An Introduction to Behavior Theory Concerning the Individual Organism. By CLARK L. HULL. viii and 372 pages. Cloth. Yale University Press. New Haven. 1952. Price $6.00.

Clark Hull's *A Behavior System,* published posthumously, is the second and last in a proposed series of three books designed to investigate what he has called "ordinary mammalian behavior." In this volume, he has attempted to apply the behavior principles set forth in *Principles of Behavior* (1943) and revised in *Essentials of Behavior* (1951) to the non-social behavior of both animals and humans. He has developed a list of 17 postulates and their corollaries, based chiefly on the behavior of the rat. From these postulates and corollaries, have been deduced over 130 theorems dealing with different aspects of non-social behavior. This book is primarily concerned with the deduction of these theorems and the agreement or disagreement between them and empirical findings, when such exist.

Hull's behavior system, which may be classified as a reinforcement theory of learning, may strike many as an over-ambitious as well as premature attempt at "pseudo-quantification" of behavior. Others may disagree with it because of his assumption that the same primary laws apply to the behavior of all mammals. They may feel that laws based on rats cannot be applied—without more intensive experimentation—to humans.

The book is not easy reading, especially for those unversed in Hullian terminology. However, Hull's behavior system has had considerable influence on current psychological work. Attempts have been made to apply his theory to social learning. This book, therefore, merits serious consideration by all those interested in the systematic investigation of behavior.

Principles of Human Relations. Applications to Management. By NORMAN R. F. MAIER. 456 pages. Cloth. Wiley. New York. 1952. Price $6.00.

A book of this type is most important during times of stress when management has employee morale problems which are affected by increasing labor turnover and by union leadership. Loyalty to management is, at present, very unstable. For this reason, public relations departments are extremely important, and this book is timely because it concerns itself with methods and principles of human relations in industry. To Professor Maier these methods and principles are not just theory. He has actually experimented with them in several existing industrial organizations. He considers that his ideas are "advanced and progressive."

Dr. Maier's emphasis is on group organization and group discussion to minimize the impression of forcing new ideas or plans and to minimize the hostility or the apathy which often appears. He offers methods of public or human relations for all grades of executives from the foreman to the top administrator. And to reinforce his ideas, the author illustrates his points by giving case histories of problem situations.

CONTRIBUTORS TO THIS ISSUE

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He is the author of *The Mind in Action,* a layman's guide to psychiatry and psychoanalysis (1947), which was also published in England and has been translated into Swedish and Italian. He is the author of many articles on psychiatric and neurological subjects. His publications in this QUARTERLY include "The Nature of Intuition" (1949) and "Cultural Aspects of a Multiple Murder" (1950).

RAYMOND R. SACKLER, M. D. Dr. Raymond R. Sackler is associate director of the Creedmoor Institute for Psychobiologic Studies and is a senior psychiatrist at Creedmoor (N. Y.) State Hospital. He has been on the medical and research staff at Creedmoor since 1945, is an editor of the *Journal of Clinical and Experimental Psychopathology,* and is author or co-author of many scientific articles dealing with endocrinology and psychiatry.

ARTHUR M. SACKLER, M. D. Dr. Arthur M. Sackler is director of research at Creedmoor (N. Y.) State Hospital and is author or co-author of a number of scientific articles on the subjects of endocrinology and psychiatry. He is director of the Creedmoor Institute for Psychobiologic Studies. Dr. Sackler has been a member of the Creedmoor hospital staff since 1944 and director of research there since 1949. He is editor-in-chief of the *Journal of Clinical and Experimental Psychopathology.*

MORTIMER D. SACKLER, M. D. Mortimer D. Sackler, M. D., is a senior psychiatrist at Creedmoor (N. Y.) State Hospital and is an associate director of the Creedmoor Institute for Psychobiologic Studies. He is an editor of the *Journal of Clinical and Experimental Psychopathology* and is author or co-author of a number of scientific articles.

JOHAN H. W. VAN OPHUIJSEN, M. D. The late Dr. van Ophuijsen, listed as a consultant in the authorship of "A Three-Year Follow-up Study of Nonconvulsive Histamine Biochemotherapy, Electric Convulsive Post-Histamine Therapy, and Electric Convulsive Therapy Controls," was director of the Creedmoor (N. Y.) Institute for Psychobiologic Studies at the time of his death in 1950. A Netherlander by birth, he had been in psychoanalytic and psychiatric practice in New York City for 15 years; and he was internationally known as a leading figure in psychoanalytic circles. He was a consultant and member of the Creedmoor research group at the time the studies reported in the present QUARTERLY article were begun.

MONTAGUE ULLMAN, M. D. Dr. Ullman received his medical degree in 1938 from the New York University College of Medicine. He served a two-year rotating internship at Morrisania City Hospital in New York City. Residency training included a year in neurology at Montefiore Hospital and a year at the New York State Psychiatric Institute. During World War II he served as neuropsychiatrist with the armed forces in this country and abroad.

Dr. Ullman completed the comprehensive course in psychoanalysis at the New York Medical College in 1948 and has since been engaged in the private practice of psychoanalysis in New York City. He is a diplomate of the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association, and an associate psychiatrist in the department of psychiatry at the New York Medical College.

JAMES H. WALL, M. D. Dr. Wall has been associated with the New York Hospital—Westchester Division since August 1, 1928, and has been medical director there since July 1, 1946. He is associate professor of clinical psychiatry at Cornell University Medical College.

JACK GREEN, M. D. Dr. Green is at present senior physician at the State Hospital for Mental Disease, Howard, R. I. Born April 16, 1923 in Poland, his early upbringing and education were in Montreal, Canada. He received his B. Sc. degree from McGill University in 1943, and his M. D., C. M. degrees from McGill University Medical School in 1947. He began psychiatric training at Queen Mary Veterans Hospital, Montreal in 1948.

Dr. Green came to the United States in 1949 as a resident in psychiatry at the State Hospital for Mental Disease at Howard. He had a personal psychoanalysis from 1949 to 1951 at Boston.

PHILLIP POLATIN, M. D. Dr. Polatin is a graduate of the College of Physicians and Surgeons, Columbia University, and has been in psychiatry for 20 years. He is now chief of the female service of the New York State Psychiatric Institute, New York City; assistant clinical professor of psychiatry at the College of Physicians and Surgeons, Columbia University; and a practising psychiatrist and psychoanalyst. His primary interests are teaching and research. He has written extensively for psychiatric journals, lectured to lay groups, and is well known as a therapist and teacher.

Dr. Polatin and the novelist, Ellen C. Philtine, were married some 25 years ago while both were still students, Dr. Polatin just starting at medical school. They have written two books together: *How Psychiatry Helps* (Harper), and *The Well-Adjusted Personality* (Lippincott). They have one son, Peter, aged 10, who attends the Riverdale Country School.

Dr. Polatin belongs to numerous psychiatric and medical associations, including the American Psychiatric Association, the American Psychoanalytic Association, the American Psychosomatic Association and the American College of Physicians. He is a member of the New York Academy of Medicine, a diplomate of the American Board of Psychiatry and Neurology and, for several years has been an assistant examiner for that board.

ABRAHAM S. EFFRON, M. D. A graduate of the Medical College of Queens University of Belfast, Ireland, Dr. Effron is now clinical assistant in psychiatry at the New York University-Bellevue Hospital Medical Center, New York City. He is also associate in neuropsychiatry at Barnert Memorial Hospital, Paterson, N. J., and assistant in psychiatry at University Hospital, New York City.

Following an internship at the Hospital for Joint Diseases, New York City, Dr. Effron had served residencies in neurology and psychiatry at Bellevue Hospital and at the New York State Psychiatric Institute, New York City. He is a frequent contributor to the medical literature.

RICHARD C. ROBERTIELLO, M. D. Dr. Robertiello is a graduate of Harvard University and of the College of Physicians and Surgeons, Columbia University (1946). He interned at Morrisania City Hospital in New York City, had a six-month residency in psychiatry at Central Islip (N. Y.) State Hospital, and served two years in the army as a neuropsychiatrist stationed at Fort Knox, Ky. He then served residencies at the New York State Psychiatric Institute and at Bellevue Hospital, New York City.

Dr. Robertiello is now in private practice in New York City and is attending the psychoanalytic course at New York Medical College. His particular interests at present are psychoanalysis and child psychiatry. Dr.

Robertiello is a member of the American Psychiatric Association, the Society of Medical Psychoanalysts and other professional bodies. He is 29 years old, is married and has two children.

BEN KARPMAN, M. D. Dr. Karpman is chief psychotherapist at St. Elizabeths Hospital, Washington, D. C. He is an internationally known writer and lecturer on psychopathological and psychoanalytic subjects. Graduated in medicine from the University of Minnesota in 1919, Dr. Karpman had analytic training in Vienna in 1923 and 1924 and again in 1926 and 1927. His books include *Case Studies of the Psychopathology of* Crime (4 vols.), *The Individual Criminal, The Alcoholic Woman,* and *Objective Psychotherapy.* He has a total of more than 90 published studies and has contributed previously to this QUARTERLY.

IRVING S. COOPER, M. D., Ph.D. Dr. Cooper is an attending neurosurgeon at Central Islip (N. Y.) State Hospital. He is a graduate of George Washington University, from which he received his M. D. (with distinction) in 1945; and he holds a Ph.D. in neurosurgery from the University of Minnesota. Following his medical school graduation, Dr. Cooper served a rotating internship at the United States Naval Hospital at St. Albans, N. Y., served for 12 months in general surgery and 12 months in neurology and neurological surgery in the United States Navy, then held a fellowship in neurology and neurological surgery at the Mayo Clinic and Foundation from April 1948 to April 1951.

He became assistant professor of neurosurgery, New York University Post Graduate School of Medicine in April 1951. He is associate attending neurosurgeon for University and Bellevue Hospitals, for the Hospital for Special Surgery and for St. Joseph's Hospital, and is attending neurosurgeon for Roslyn Park Hospital—all in New York City or the metropolitan area. Dr. Cooper is a member of the American Medical Association, the American Federation for Clinical Research and other professional organizations. He is a diplomate of the National Board of Medical Examiners and a diplomate in neurology of the American Board of Psychiatry and Neurology, for which he is an assistant examiner.

NEWS AND COMMENT

FIFTH WORLD MENTAL HEALTH CONGRESS IN TORONTO

The World Federation for Mental Health announces that the Fifth International Congress on Mental Health will be conducted in Toronto, from August 14 to 24, 1954. The previous congresses were in Washington, Paris, London and Mexico City; and the world federation developed from the third in London in 1948. It has a membership of 72 mental health and professional societies in 38 countries and has consultative status with UNESCO and the World Health Organization.

The theme of the fifth congress will be "Mental Health in Public Affairs"; and it will be held at the University of Toronto.

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HENRY ALDEN BUNKER, M. D., DIES IN NEW YORK AT 63

Dr. Henry Alden Bunker, formerly with the New York State Department of Mental Hygiene and a practitioner of psychiatry and psychoanalysis in New York City for many years, died at his home there on March 19, 1953 after a long illness. He was 63 years old. Dr. Bunker was assistant director of the New York State Psychiatric Institute from 1921 to 1926 when it was still on Ward's Island. He resigned in the latter year to enter private psychoanalytic practice.

Dr. Bunker had been an associate editor of the *Psychoanalytic Quarterly* since 1933; he was author of a number of psychoanalytic articles and was a translator of Freud; he was president of the New York Psychoanalytic Society, 1948-50. Born in Brooklyn and a graduate of Harvard Medical School in 1915, Dr. Bunker had served a psychiatric internship in Boston before joining the army medical corps in World War I and doing psychiatric work overseas. He was in practice in Massachusetts for two years following the war, then joined the staff of the Psychiatric Institute. Dr. Bunker leaves his widow, three daughters and a son, all of New York City.

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COHEN NAMED CLINICAL DIRECTOR OF HEALTH INSTITUTE

Dr. Robert A. Cohen has been appointed clinical director of the National Institute of Mental Health, it has been announced by Dr. Leonard A. Scheele, surgeon-general of the United States Public Health Service. Dr. Cohen goes to the public health service from Chestnut Lodge, Rockville, Md., where he has been clinical director since 1948. He will be in charge, for the National Institute of Mental Health, of a program of clinical research into mental diseases and psychotherapy which is to be conducted in the clinical center that is nearly completed in Bethesda, Md.

YALE RECEIVES GRANT FOR PSYCHIATRIC RESEARCH

A grant of $6,000,000 to Yale University by the Social Research Foundation has been announced—the purpose being "to support research into why people become mentally and emotionally ill, why they get well, how best to help them get well and how best to help them from becoming mentally and emotionally ill." The foundation announces that distribution of this fund will not be confined to Yale and that it is planned to spend both income and principal in about twenty years.

A board of directors of scientists, not more than two of which may be from a single institution, is to administer the fund. The present directors, named by the Yale Corporation, are: Frederick C. Redlich, M. D., and Vernon W. Lippard, M. D., Yale University School of Medicine; Charles D. Aring, M. D., Cincinnati College of Medicine; John D. Benjamin, M. D., University of Colorado; David Shakow, Ph.D., University of Illinois College of Medicine; George W. Thorn, M. D., Harvard Medical School; and John C. Whitehorn, M. D., the Johns Hopkins University. Dr. Redlich, who is professor of psychiatry at Yale, is chairman.

The board held its first meeting in New Haven, March 27 and 28, 1953. Dr. Sibylle Escalona, research psychologist in the Yale Child Study Center, was appointed executive officer. The foundation has a temporary address at 333 Cedar Street, New Haven 11, Conn. The board has issued an invitation for communications of ideas but announces that it will not be ready to make decisions on grants for at least six months.

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DR. MERRIMAN, FORMER HOSPITAL HEAD, DIES AT 77

Willis E. Merriman, M. D., former head of Utica and Manhattan (N. Y.) State Hospitals, who retired as director of the Utica hospital in 1946, died at his home in Utica on February 14, 1953 at the age of 77. Dr. Merriman, born in Albany, N. Y., and a graduate of the Albany Medical College in 1902, had spent most of his professional career in the service of New York State, first as an assistant physician at the New York State Hospital for Incipient Pulmonary Tuberculosis, but principally in the hospitals of the Department of Mental Hygiene. He became superintendent of Manhattan State Hospital in 1933, and, in 1939, was transferred to head the Utica institution.

Dr. Merriman was a life fellow of the American Psychiatric Association and a member of numerous professional and other societies. In his earlier years, he was author or co-author of a number of scientific papers, including publications in this QUARTERLY. Dr. Merriman had lived in Utica since his retirement. He leaves his widow, the former Lena May Eggers Saunders, to whom he was married in 1943, and a brother.

MURIEL IVIMAY, M. D., PSYCHOANALYST, DIES AGED 64

Dr. Muriel Ivimay, one of the founders with Karen Horney of the American Institute for Psychoanalysis and formerly its associate dean, died following a coronary occlusion in New York Hospital on February 26, 1953. She was 64 years old. Born in London and brought to this country as a small child, Dr. Ivimay was graduated from the Johns Hopkins Medical School in 1922, and following a two-year internship at the Henry Phipps Psychiatric Clinic, the Johns Hopkins Hospital, had been in the practice of psychiatry and psychoanalysis ever since. In the course of her long professional career, she had served on the staffs of the outpatient department of the Phipps Psychiatric Clinic, the old Cornell Clinic, the outpatient department of the New York Infirmary for Women and Children, the Vanderbilt Clinic, the outpatient department of the New York Neurological Institute, and the outpatient department of the Payne Whitney Psychiatric Clinic of New York Hospital.

In the medical education field, Dr. Ivimay had taught psychiatry, neurology and psychoanalysis at the Henry Phipps Clinic, the New York University Medical College, the Payne Whitney Psychiatric Clinic, the New School for Social Research, and the American Institute for Psychoanalysis, where she was training analyst and instructor at the time of her death. She had conducted clinics for a number of social agencies.

Dr. Ivimay was the author of a number of scientific articles on psychoanalysis, neurology and other medical topics. She was a member of the American Psychiatric Association, the Association for the Advancement of Psychoanalysis, the New York Neurological Society and other professional organizations. She is survived by two sisters and a brother.

DR. HENRY NAMED HEAD OF FRIENDS AND FAMILIES GROUP

George W. Henry, M. D., associate professor at Cornell University Medical College and attending psychiatrist at New York Hospital has been elected president of the American Association of Friends and Families of Psychiatric Patients. Other new officers are: Edward M. Shepard, M. D., of the Cornell Medical College faculty and the Payne Whitney Psychiatric Clinic, vice-president; Maurice J. Shore, Ph.D., director of Saint Edwards Consultation Clinic, executive vice-president; and Howard M. Newburger, Ph.D., secretary-treasurer. The association aims to aid both patients and their families in such problems as advice on individual treatment, arrangements for hospitalization, care of patients' estates, readjustment of convalescent and paroled patients, and other matters consequent on mental illness.

DATA SOUGHT IN STUDY OF ENDOCRINE DISORDERS

Material on cases where endocrine disorders, particularly hyperthyroidism and hypoglycemia, may be implicated in crime is being sought by Wladimir Eliasberg, M. D., of 151 Central Park West, New York 23, N. Y.; and he has asked this QUARTERLY to inform its readers that he would welcome any pertinent data. He has been circulating a questionnaire among lawyers, designed to determine for computation purposes, some idea of the prevalence of cases in which either the attorneys themselves or medical experts believed there might be a relationship between endocrine disturbance and crime. He is interested in percentages of such cases, in reliability of diagnoses, and in the legal disposition of cases where irresponsibility on the basis of hypoglycemia or thyroid toxicity was pleaded as defense. He is also interested in other details, including characteristic case histories; and he has asked THE QUARTERLY to say he would be glad to have any pertinent information from medical sources.

AMERICAN ORTHOPSYCHIATRIC ASSOCIATION REORGANIZED

The reorganization of the American Orthopsychiatric Association, to further its program of co-operation by psychiatrists, social workers and psychologists in the study and treatment of mental and emotional disorder, has been announced by the association's president, Morris Krugman, Ph.D., of Brooklyn, psychologist and assistant superintendent of schools for the New York City Board of Education. Dr. Krugman announced that Marion Langer, Ph.D., of New York City, social welfare administrator and college teacher of sociology and social work, had been named executive secretary of the association. The association plans, Dr. Krugman says, to promote further regional organizations in various parts of the country and to work more closely with other professional organizations which share its interests. Hyman S. Lippman, M. D., of St. Paul, Minn., is to succeed Dr. Krugman as president for the coming year.

CHILD PSYCHIATRY ACADEMY IS ORGANIZED

A new national medical society to be known as the American Academy of Child Psychiatry was founded in Cleveland in February with a membership of about a hundred specialists. George E. Gardner, M. D., of Boston, was chosen president; Fred Allen, M. D., of Philadelphia, president-elect; Frank J. Curran, M. D., of Charlottesville, Va., secretary, and Mabel Ross, M. D., New York City, treasurer. The academy announces that membership is limited to members of the American Psychiatric Association with at least two years of training in child psychiatry in an adequate clinic setting and at least five years of experience in child psychiatry following the training period. A member's chief professional interest and activity must also be in the field of child psychiatry.

STRESS RESEARCH REPRINTS ARE SOUGHT BY HANS SELYE

Hans Selye, M. D., and his co-worker, Alexander Horava, M. D., of the Institute of Experimental Medicine and Surgery, Université de Montréal, Montreal, Canada, have asked THE PSYCHIATRIC QUARTERLY to call the attention of its readers to their need for reprints of scientific articles "pertaining to research on 'stress' and the so-called 'adaptive hormones' (ACTH, STH, corticoids, adrenergic substances, etc.)."

The institute of which Dr. Selye is director commenced in 1950 the publication of a series of reference volumes, *Annual Reports on Stress,* in which it is endeavored to survey the entire current world literature, usually, say the compilers, between 2,000 and 4,000 publications. The material for the *Annual Reports* has been compiled directly from publications, from monographs, from abstract journals and from reprints sent to the institute by the authors themselves. Drs. Selye and Horava say such reprints are the best sources and report that they have sent out individual requests to several thousand authors engaged in stress research to submit their reprints. Noting that even this procedure failed to give the coverage desired because of failure to reach some authors and failure to receive reprints from others promptly, the Montreal scientists are now requesting medical journals to ask any readers publishing material on stress to send reprints to the Institute of Experimental Medicine and Surgery as soon as reprints are available.

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"HAND-TALKING" CHART DEVELOPED FOR APHASICS

Hamilton Cameron, M. D., 601 West 110th Street, New York 25, N. Y., has asked THE QUARTERLY to call attention to a "hand-talking" chart he devised for one-hand use when he himself was in a state of right hemiplegia and "complete" aphasia following coronary thrombosis and cerebral embolism. This chart contains 20 signs, made by one hand and covering simple communication needs and some of the requests most likely to be made by the patient. The alphabet and numerals are appended to the chart for the use of a patient who is able to read and able to point with a pencil to spell out further communications. Dr. Cameron states that he visualized the chart while he was completely helpless during the first four weeks of his illness, but that it was two and one-half years before he was able to communicate his ideas orally to an artist who made the drawings. He considers the chart part of a rehabilitation process which ended in apparent complete physical recovery only after six years.

Dr. Cameron's chart and reports of its development and use have appeared in the *Medical Times* and *Arizona Medicine,* and the *New England Journal of Medicine* devoted an editorial to it. The chart is available to physicians on application to Dr. Cameron.

BEATRICE HINKLE, M. D., PSYCHOANALYST, IS DEAD AT 78

Dr. Beatrice M. Hinkle, New York City psychiatrist and psychoanalyst since 1905, died at the age of 78 in New York City on February 28, 1953 after a short illness. A graduate of Cooper Medical College (now the medical department of Stanford University) in 1899, Dr. Hinkle was city physician of San Francisco from 1899 to 1905, one of the earliest instances of a woman holding such a public health post.

Dr. Hinkle founded what is said to have been the first psychotherapeutic clinic in the United States at Cornell Medical College in 1908. She was the author of numerous scientific articles and a book, *The Recreating of the Individual*, and she was translator of C. G. Jung's *The Psychology of the Unconscious*. She was a member of the American Psychiatric Association and other professional groups.

Dr. Hinkle was married in 1892 to Walter Scott Hinkle, San Francisco attorney, who died in 1899. She leaves a son, a daughter and four grandchildren.

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PSYCHIATRIC NURSING DISCUSSION TO OPEN CONVENTION

The newly-formed interdivisional council on psychiatric and mental health nursing of the National League for Nursing will meet on Monday, June 22, 1953, in Cleveland, the first day of the league's first convention, which will be conducted from June 22 through June 26. Officers will be introduced, and the purposes of the interdivisional council will be discussed. Dr. Bernard H. Hall, clinical psychiatrist of the Menninger Foundation, will speak in the evening on, "A Colleague Looks at Psychiatric Nursing," and a general discussion of trends and needs in psychiatric nursing will follow.

Other special sessions, as well as general meetings of wider interest will be conducted during the convention week. Additional information can be obtained by writing to the league headquarters, 2 Park Avenue, New York 16, N. Y.

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GILBERT M. BECK, M. D., OF BUFFALO MEDICAL SCHOOL, DIES

Gilbert M. Beck, M. D., psychiatrist and neurologist, and psychiatrist-in-chief at the University of Buffalo Medical School, where he had been a faculty member for 24 years, died in Buffalo on January 9, 1953 at the age of 53. Dr. Beck received his medical degree from the University of Buffalo in 1923, completed an internship and residency, became an assistant in neuroanatomy and psychiatry at the Johns Hopkins Hospital, then studied in England, Holland and Germany. He returned to Buffalo Medical School in 1929. During World War II, Dr. Beck served in the Army Medical Corps in the North African theater and in the invasion of southern France; he attained the rank of lieutenant colonel. He is survived by a brother, Dr. Edgar C. Beck.

LABORATORY ANIMAL LAW REPORTED A BENEFIT

An increase in the supply of laboratory animals for scientific purposes to the point where the New York State Society for Medical Research considers it "almost adequate," was reported by New York State Health Commissioner Herman E. Hilleboe, M. D., as a result of the first six months of operation of the law providing that unclaimed animals in state-supported pounds may be turned over to approved laboratories for medical experiments. The commissioner reported that, besides a material increase in the numbers of experimental animals, particularly in New York City, the state-approved competition had increased the available supply on the private market. Quarterly inspections, required by state regulations, had shown animals' quarters to be generally adequate and had revealed general cooperation by the laboratories in giving proper care to experimental subjects, the commissioner's announcement said.

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WILLIAM DRAYTON, JR., M. D., DIES IN PHILADELPHIA AT 72

Dr. William Drayton, Jr., Philadelphia psychiatrist for many years, died in the Veterans Hospital in Coatsville, Pa., on March 17, 1953 after a long illness. Dr. Drayton, 72 years old, became widely known in forensic psychiatry after his appointment in 1926 as psychiatrist to the medical department of the Philadelphia municipal court, where he made many appearances as a commonwealth witness. He leaves his widow, Dr. Winifred B. Stewart of Philadelphia.

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VIENNA PSYCHOTHERAPY ASSOCIATION REVIVED

The Vienna society known as the *Allegemeine Aerztliche Gesellschaft für Psychotherapie,* which was dissolved by Hitler, has been revived, according to a communication received by Wladimir Eliasberg, M. D., of 151 Central Park West, New York 23, N. Y. The original society, founded by Dr. Eliasberg in 1926, held seven congresses before its suppression by the Nazis. The new society, according to the communication from Dr. Viktor E. Frankl, president, has voted to make Dr. Eliasberg an honorary member. The original society is said to have been the first amalgamation into a covering organization and the first institution of a common forum of the various schools of psychotherapy current when it was founded. Dr. Eliasberg informs THE QUARTERLY that he still has the records of the seven original congresses and that they are of considerable value for the history of psychotherapy.

GENERAL SEMANTICS WORKSHOP IN AUGUST

The tenth summer seminar-workshop in general semantics of the Institute of General Semantics has been announced for August 15 to 30, 1953, with an optional post-session from August 31 to September 3. The sessions will be conducted at Bard College, Annandale-on-Hudson.

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DR. SAMUEL FEIGIN, NEW YORK CITY PSYCHIATRIST, DEAD

Samuel Feigin, M. D., widely known for many years in New York psychiatric circles as a practitioner and consultant, died March 20, 1953 in Palm Beach, Fla., where he had been convalescing following a heart attack. He was 58.

Dr. Feigin, a graduate of New York University College of Medicine, had a long record of public service. He interned at Bellevue Hospital, New York City, was on the staff of Manhattan (N. Y.) State Hospital; and was assistant and then acting director of the psychiatric division at Bellevue for 14 years. Among other activities, he reorganized the psychiatric service of Kings County (N. Y.) Hospital; assisted in organizing the psychiatric clinic at the New York County Court of General Sessions; was psychiatric consultant for the New York City Board of Education and was psychiatrist for the New York City Police Department.

He was past president of the New York Society for Clinical Psychiatry and a member of other professional societies. He had devoted himself to a large consulting practice in recent years. Dr. Feigin leaves his widow, a son and three brothers.

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RICHARD H. HUNGERFORD, *Editor*

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